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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

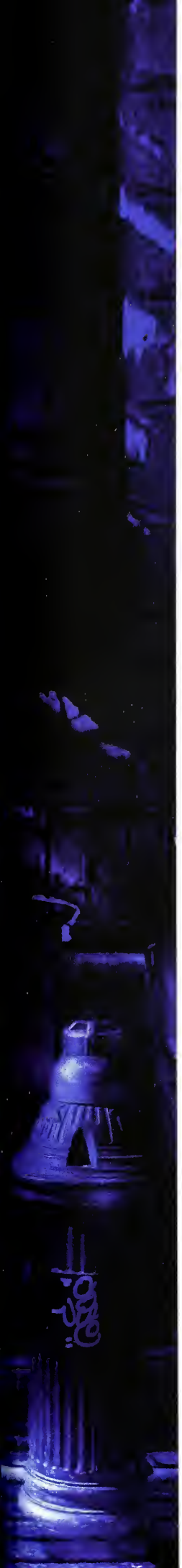
8 December 2001

PSNC threaten legal action on dispensing fee

Wales calls for action on poor script checks

PI usage set to rise by 120pc over five years

Shortages of generics still a real danger



STAND UP TO FOOD ATTACK

For sufferers of heartburn and indigestion, it can take no more than a simple meal for a painful attack to start.

Now you can get tough with difficult food.

Arm your customers with Zantac 75 and good advice, and let each small tablet work quickly to fight excess acid and keep food friendly ***all through the day or night.***

12 TABLETS

Zantac 75™ Relief

HEARTBURN & INDIGESTION RELIEF FOR UP TO 12 HOURS

ranitidine (as HCl)

A force for comfort

Zantac 75 Relief 12's Product Information
Presentation: each tablet contains 75mg ranitidine. **Uses:** Symptomatic relief of heartburn, indigestion, acid indigestion and hyperacidity. **Dosage and Administration:** Adults and children aged 16 and over, one tablet. No more than two tablets should be taken in any 24-hour period. **Contraindications:** Hypersensitivity. **Precautions:** Treatment should be restricted to maximum of 6 days continuous use at any one time. Patients should contact their doctor if their symptoms do not improve after 6 days continuous treatment. Should not be taken by the following groups of patients unless under medical supervision: those with difficulty swallowing, persistent stomach pain or unintended weight loss; those middle aged or older with new or recently changed symptoms of indigestion; during pregnancy or in those trying to become pregnant, or breast feeding; those taking NSAIDs or with a history of porphyria. **Side Effects:** Generally well tolerated. Rarely headaches, dizziness, confusion, depression, hallucinations, involuntary movement disorders, changes in liver function tests, hepatitis, jaundice, acute pancreatitis, leucopenia, thrombocytopenia, agranulocytosis, pancytopenia, marrow hypoplasia, aplasia, hypersensitivity reactions, bradycardia, A-V block, skin rash, vasculitis, alopecia, musculoskeletal symptoms, impotence and breast swelling/discomfort in men. See SPC for further details. **Legal Category:** GSL. **Retail Selling Price (ex VAT):** Zantac 6's £1.69, Zantac 12's £3.31. **Product Licence Number:** PL 10949/0313. **Licence Holder:** Glaxo Wellcome UK Limited, Stockley Park West, Uxbridge, Middlesex, UB11 1BT. Further information available on request from: Medical & Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Wallis House, Great West Road, Brentford TW8 9BD. **Date of preparation:** May 2001. ZANTAC 75 RELIEF and ZANTAC 75 DEVICE are registered trademarks of the GlaxoSmithKline Group of Companies

Prescribing Information (PI)

(Please refer to the full SPC before prescribing)

Zyban 150 mg prolonged release tablets (bupropion HCl)

Uses Smoking cessation (with motivational support) in nicotine-dependent patients. **Dosage and administration** *Adults from 18 years:* Start treatment while still smoking and set 'target stop date' in second week. 150 mg o.d. for 6 days, then 150 mg b.d. for remainder of 7 to 9 week course. Maximum 150 mg single dose and 300 mg daily. Allow at least 8 hours between doses. Swallow tablets whole – do not crush/chew. Discontinue if no effect at week 7. *Elderly, renal or mild-to-moderate hepatic impairment:* 150 mg o.d. **Contra-indications** Hypersensitivity, current seizure disorder/history of seizures, CNS tumour, abrupt alcohol/benzodiazepine withdrawal, current/previous eating disorder, severe hepatic cirrhosis, recent/current MAOIs, bipolar disorder. **Precautions** Predisposition to lowered seizure threshold/increased risk of seizures (includes previous head injury, other medications, alcohol abuse, diabetes, use of stimulants/anorectic products) – use only if the medical benefit of stopping outweighs the increased risk of seizure – consider using 150 mg o.d. for these patients; renal or mild-to-moderate hepatic impairment; elderly; susceptibility to psychotic episodes. **Drug interactions** Theophylline, tricyclics, SSRIs, MAOIs, antipsychotics, beta-blockers, class 1c antiarrhythmics, enzyme inducers/inhibitors, orphenadrine, cyclophosphamide, levodopa, antimalarials, tramadol, quinolones, sedating antihistamines. **Pregnancy and lactation** Not recommended. **Side effects** *Common:* dry mouth, gastrointestinal pain/upset, insomnia, tremor, concentration disturbance, headache, dizziness, depression, agitation, anxiety, rash, pruritus, urticaria, sweating, fever, taste disorders. *Uncommon:* chest pain, asthenia, tachycardia, blood pressure changes, flushing, confusion, anorexia, tinnitus, visual disturbance. *Rare:* vasodilation, syncope, seizures, irritability, hostility, severe hypersensitivity reactions including anaphylaxis, arthralgia, myalgia and fever, erythema multiforme, Stevens Johnson syndrome. Discontinue if seizure, hypersensitivity reaction or anaphylaxis occurs. **Presentation and basic NHS cost** 60 tablets £42.85. **Product licence (PL) no.** PL10949/0340. **PL holder** Glaxo Wellcome UK Ltd., Stockley Park West, Uxbridge, UB11 1BT.

POM

Further information is available from:
Customer Contact Centre, GlaxoSmithKline, Stockley Park West, Uxbridge, Middlesex UB11 1BT.
E-mail customercontactuk@gsk.com
www.themeisright.co.uk
www.right-time.co.uk
www.zyban.co.uk
Freephone: 0800 221441

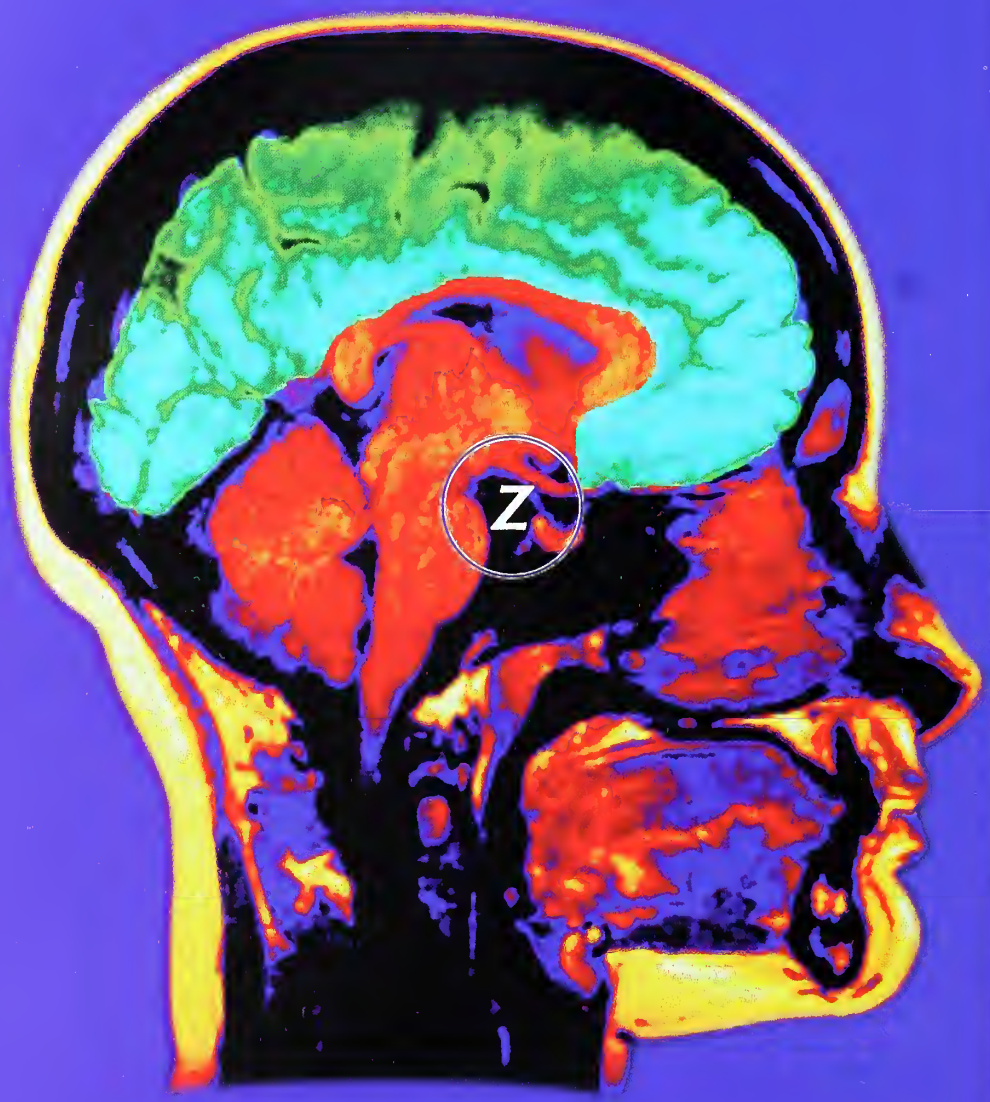
References

1. Leshner AI. Hosp Pract 1996; **Oct 15**: 47-59.
2. Ferry LH. Prim Care Clin Off Pract 1999; **26**: 653-669.
3. Covey LS, Sullivan MA, Johnston JA, *et al*. Drugs 2000; **59**(1): 17-31.

gsk GlaxoSmithKline

FOR SMOKING CESSATION

Z MARKS THE SPOT



Nicotine addiction is a neurobiologically-mediated brain disease.[1] Zyban is a unique non-nicotine tablet therapy that works in the brain by acting on the neurotransmitters involved in nicotine addiction and withdrawal.[2,3]

Zyban®
bupropion HCl SR
Science against smoking

GEN 26847/A - September 2001

www.dotpharmacy.com

C&D

Chemist & Druggist

The News Weekly for Pharmacy

Volume 256 No 6320
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This week

Pharmacy today

Regulars

Features

PSNC

PSNC threatens action over fees

The Pharmaceutical Services Negotiating Committee has invited the Health Minister Hazel Blears to review her decision to reduce the dispensing fee to 87.4p from November 1. If she does not do so then PSNC intends to seek a judicial review.

In a letter sent to Ms Blears last Friday, PSNC "invited" the minister to accept that her decision was being made on a fundamentally flawed basis. She has been given a deadline of December 28 to respond.

At a meeting with PSNC in mid-November and at the NPA dinner last week *(C&D December 1, p6)* Ms Blears said she was bound by the rules of the global sum system of payment. This required her to recover the overpayment made to contractors caused by last year's prescription volume increases.

PSNC says there are no binding rules. The global sum system is a means by which a sum of money to fund the community pharmacy dispensing system is calculated. "It has not been specified within legislation and therefore ministers are not bound to comply with it."

Sue Sharpe, PSNC's chief executive, said: "We hope that she will recognise that the disastrous decision she made was reached on a false understanding of her position and that we can expect a revised decision that sets a reasonable fee."

There was "absolutely no dissent" within the Committee about the course of action that is being taken, she added. PSNC can afford a legal challenge without having to seek additional funds from LPCs.

The Company Chemists Association has given its unanimous support to the PSNC. Digby Emson, chairman of the CCA, said: "The CCA supports the PSNC's activity in this area in seeking to ensure that contractors' additional workload is being assessed fairly."

For more information:
www.psnc.org.uk

SURVEY

Young people at risk

Smoking, drinking and drugs misuse among young people increased between 1999 and 2000, according to a national survey of 7,000 school children aged 11-15 published by the Department of Health.

The proportion of pupils who smoked at least one cigarette a week increased to 10 per cent in 2000, a rise of 1 per cent from 1999. Smoking also increased sharply with age, with 23 per cent of 15 year olds smoking regularly.

The number of pupils who had drunk alcohol in the previous week also rose to 24 per cent in 2000. This figure rose again with age to 49 per cent of 15 year olds.

Class A drug usage among pupils was also higher at 9 per cent. However, cannabis was the most likely drug to be used. Some 28 per cent of 15 year olds said they had used it in the last year.

Although 6 per cent said they had been offered heroin or methadone, only 1 per cent had used them.

For more information:
www.doh.gov.uk

PATIENTS

Complaints leaflet

The Health Service Ombudsman's office has revised its information leaflet, giving details on how to make a complaint. A form helps complainants put their case in writing. The leaflet is available in several ethnic minority languages, Braille, audio cassette and large print

For more information:
Tel: 020 7217 4942
E-mail: OHSC.Enquiries@ombudsman.gsi.gov.uk

Questiontime

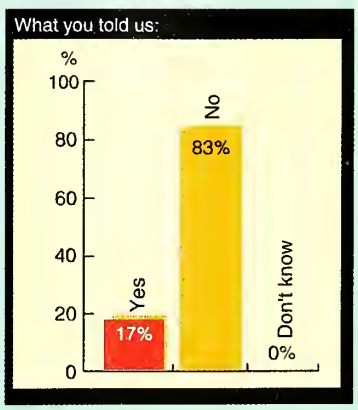
The Royal Pharmaceutical Society is proposing to close the museum as part of its budgetary cuts. Do you support this move?

● Yes ● No ● Don't know

You can record your vote on our website:*www.dotpharmacy.com*. On the home page you will find a link to the Question Time page. Select your answer and then click on the "vote" box. Your answer is automatically collated.

You have until noon on December 11 to cast your vote. We will publish the result in *C&D*, December 15.

Last week we asked you:
Do you still have confidence in the PSNC as a negotiating body after the recent pay imposition?



APPOINTMENTS

Pharmacists on the CSM

Dr Terenee Maguire from Northern Ireland has been appointed to the Committee on Safety of Medicines, along with Alison Blenkinsopp, Professor of Practice of Pharmacy at Keele University, who was re-appointed.

Dr Maguire recently stood down as director of the Northern Ireland Centre for Pharmacy Postgraduate Education and Training in October (*see C&D, Oct6, p4*).

● Lord Hunt also announced that Peter Noyce, Professor of Pharmacy Practice, University of Manchester, has been appointed to the Medicines Commission.

Rise in ESPS payments

The annual target payment for the 287 contractors in the Essential Small Pharmacy Scheme has risen to £40,350 for 2001-02, in line with the global sum.

The qualifying threshold is now 23,040 prescriptions and the maximum monthly payment is £2,900. To make the back payment from April, the maximum monthly payment will increase to £3,870 for December.

This month's Update question paper enclosed

Enclosed in this week's issue is the questionnaire (2217) for the following Pharmacy Update modules carried in November:

● Exploring Candida (1217)
● The digestive tract (1218)
● Ovarian cancer (1219)

Pharmacy Update is a distance learning programme accredited by the College of Pharmacy Practice. Previous modules can be obtained by using the faxback service on 08705 441188 or accessing the dotPharmacy website at *www.dotpharmacy.com*.

The Pharmacy Update multiple choice questionnaire and telephone marking service are supported by Genus Pharmaceuticals.

GSK's very own Covent Garden: the company's new 93,000m² corporate headquarters is made up by three five-storey buildings linked by a 142m "street". It also includes a 16-storey car parking tower. Facilities along the street include a Londis store, a hairdresser, bank, dry cleaner and a health and fitness centre. A pharmacy is, however, conspicuously absent. GSK staff are being moved into the new premises in stages until March 2002

NPA backs study on PTC consortias

The National Pharmaceutical Association's Board has agreed that a paper be prepared setting out the case for pharmacy consortia in primary care centres.

The NPA believes that when a new primary care centre is built, all affected proprietors should be given the chance to join a consortium in the centre. There should not be a monopoly in which one contractor could pay for the exclusive right to operate there.

At the November meeting, Board members were concerned that pharmacies should not be forced out of business in this way. It was in the public interest for pharmacy owners to co-operate with one another and so provide the best possible arrangements for the public.

Costs of clinical governance

The NPA is concerned as to how clinical governance strategies for community pharmacy could be implemented without additional funding.

The NHS guidelines suggest that "health authorities and PCTs should invest accordingly" but the NPA thought this could be interpreted in different ways, leading to postcode variations in standards.

The Board agreed there was a need for core standards to be implemented nationally, so the NPA will produce a resource pack for PCTs and health authorities.

PCT members' task force

The NPA, Company Chemists Association and Pharmaceutical Services Negotiating Committee have organised a meeting for pharmacist members of PCT executive boards to discuss ways that pharmacy organisations could support them.

Monitoring of advertising

The Pharmaceutical Group of the European Union intends to monitor a five year pilot in which manufacturers will be able to provide information on certain Prescription Only Medicines directly to the public.

The PGEU aims to make sure that the outcome is in the best interest of the patient and that only accredited information is available. The group would also oppose any proposal to allow direct to consumer advertising of POMs.

Private-Rx website sold to economist

Private-Rx, the pharmacist-only website, has been sold to Dr Darrin Baines, a health economist.

Simon Whitaker, proprietor of the site, said that it had become so busy it was no longer possible to run it in his spare time and it was a choice of closing or selling the site.

Dr Baines, director of medM, confirmed that Private-Rx would remain "exclusive, independent and free". He said that his motivation for buying the site was not commercial. "As an academic I can see the value in things like this."

He also confirmed that there will be no changes to the site unless they are approved by the steering committee. People can e-mail Dr Baines with any suggestions for the website.

There are currently just over 1200 pharmacists members of Private-Rx.

For more information :

www.private-rx.co.uk

E-mail: *director@medm.co.uk*

Back to school with Lloydspharmacy

Lloydspharmacy is investing over £20,000 to provide 20 of its pharmacists with an opportunity to undertake a postgraduate medicines management training programme at Keele University.

The distance learning programme starts in December and provides pharmacists with an understanding of medicines management and pharmaceutical care.

The company is paying for course fees, locum costs and travelling expenses. Lloydspharmacy is investigating further learning opportunities for next year.

Drug recall by Aventis

Further to the drug recall issued by Aventis Pasteur MSD on November 20 *(C&D, November 24, p5)* the company is recalling all remaining batches of Vaqta injections, adult and paediatric.

Patients who have received the vaccine should be advised to contact their doctor as they may not have received adequate protection against hepatitis A.

For more information:

Tel:0800 587 2390.

Interactive NHS enquiry service

A new-look NHS Direct Online site, which includes an interactive enquiry service, is now up and running. Patients also have access to a new health encyclopaedia of over 400 topics.

Hazel Blears, health minister, has announced a fourth pilot, to provide health information through digital interactive TV to viewers in Hull and East Yorkshire.

For more information:

www.nhsdirect.uk

OFT control of entry survey

The Office of Fair Trading (OFT) is consulting pharmacists as part of its ongoing review of control of entry regulations.

The OFT has issued a questionnaire asking pharmacists about the likely impact on patients if the existing arrangements were to be relaxed. It also includes a series of questions relating to turnover and opening hours.

For more information :

www.oft.gov.uk

N Ireland to opt in with rest of UK under CRHP

The Pharmaceutical Society of Northern Ireland's Council has decided it is better to join with the rest of the UK over professional self-regulation, rather than going it alone.

The Council thinks the advantages of coming under UK legislation far outweigh the disadvantages. Members agreed at the October meeting that it would be a positive move to be included in the proposed UK Council for the Regulation of Healthcare Professions (CRHP). If necessary, PSNI could fight for autonomy from within.

Although Northern Ireland is not mentioned in the consultation document *Modernising the Regulation of Healthcare Professions*, it is extremely unlikely that a parallel system would be set up for the province. If N Ireland is not included, primary legislation taking one or two years would be needed and there would be questions of parity with pharmacists in Great Britain.

- A quorum was not reached at the Society's annual meeting on October 18, so four proposed changes to the Code of Ethics could not be ratified. A further special meeting will be needed.
- Western Health & Social Services Board has turned down a further request for financial support for the McBrien and McSorley Statutory Committee inquiry, suggesting that PSNI should recoup the deficit.

Clarifying the resourcing of such inquiries, Mrs Maltby said PSNI only paid for cases it brought before the Statutory Committee; other parties had to pay for cases they brought. It was agreed that all cases should be brought before Council before being referred to the Statutory Committee.

- The Ethics and Law Committee is exploring issues surrounding mandatory continuing professional development.
- Reciprocal registration was approved for Miss Shauna O'Brien, 21 Hereford Place, Cheltenham, Glouc GL50 4JQ.
- Dr Terry Maguire was co-opted to fill the vacancy on Council and Mrs M Singleton to fill a vacancy on the Statutory Committee.

Pharmacists in Wales face sanctions on script checks

The Audit Committee of the National Assembly for Wales has called for tougher sanctions against pharmacists who consistently fail to check prescription exemptions.

The call for sanctions was prompted by its report, *Maximising Income from Prescription Charges*, in which the Assembly says the NHS in Wales could be losing £15 million a year because patients are receiving free prescriptions when they are not entitled to them. Income from prescription charges is estimated at £23m for 2000-01

The report says the reasons that some pharmacists are not checking exemptions fully could be because they are unwilling to damage their relationship with patients. It also suggest that the criteria for exemption is too complicated.

Community Pharmacy Wales, which offered evidence to the Assembly in defence of pharmacists, said: "A busy pharmacy is a difficult environment in which to carry out point of dispensing checks, particularly when a patient is not prepared to co-operate."

Key areas identified by the report where action is needed are:

- Providing better information to pharmacists about patient exemption criteria.
- Having a better definition of the standard of performance expected from pharmacists in assessing entitlement to exemption.
- Having a more effective incentive for pharmacists to discharge their point of dispensing responsibilities.
- Having sanctions against pharmacists who consistently fail in checking exemptions properly.

For more information :
www.wales.gov.uk

The supervision debate: there must be no relaxation of legal rules, says NPA

The National Pharmaceutical Association has welcomed the news that the Royal Pharmaceutical Society is to re-open the supervision debate.

The NPA supports the Society's view that pharmacists must be freed from the mechanical aspects of dispensing to spend more time with patients.

But the Association is adamant that there should be no relaxation of the current legal supervision requirements, as interpreted in the Code of Ethics and Professional Standards document.

Any move to do this would be of great detriment to the profession, both nationally and internationally, it says.

The NPA Board decided at its November meeting that any debate must highlight public safety as a priority. During dispensing, every prescription should be seen at least once by a pharmacist so that a professional assessment can be carried out.

The NPA says a pharmacist must be on the premises at all times when prescriptions are dispensed, or when Pharmacy medicines are sold.

Seventeen dispensers have been awarded the Boots Dispensing Distinction Award, for achieving more than 90 per cent in their exams and coursework. Digby Emson, pharmacy superintendent, presented nine of the winners with their awards at Boots head office recently. From left to right: Digby Emson, pharmacy superintendent, Nick Ryan and Denise Briggs (professional development), Liz Newby (contract manufacturing specials), Lyndsey Mutch Alan Sare (development), Pam Hedges, Anne Sorrell, Joan Chilton (development), Sandra Peel, Paul Read, Rebecca Ross, Julie Brereton, Steve Churton (assistant pharmacy superintendent), Lesley Hall, Derek Webb, and course tutor Effie Pitsillides

DOUBLE WWHAM-Y

New, pharmacy only, double strength (10% ibuprofen) gel.

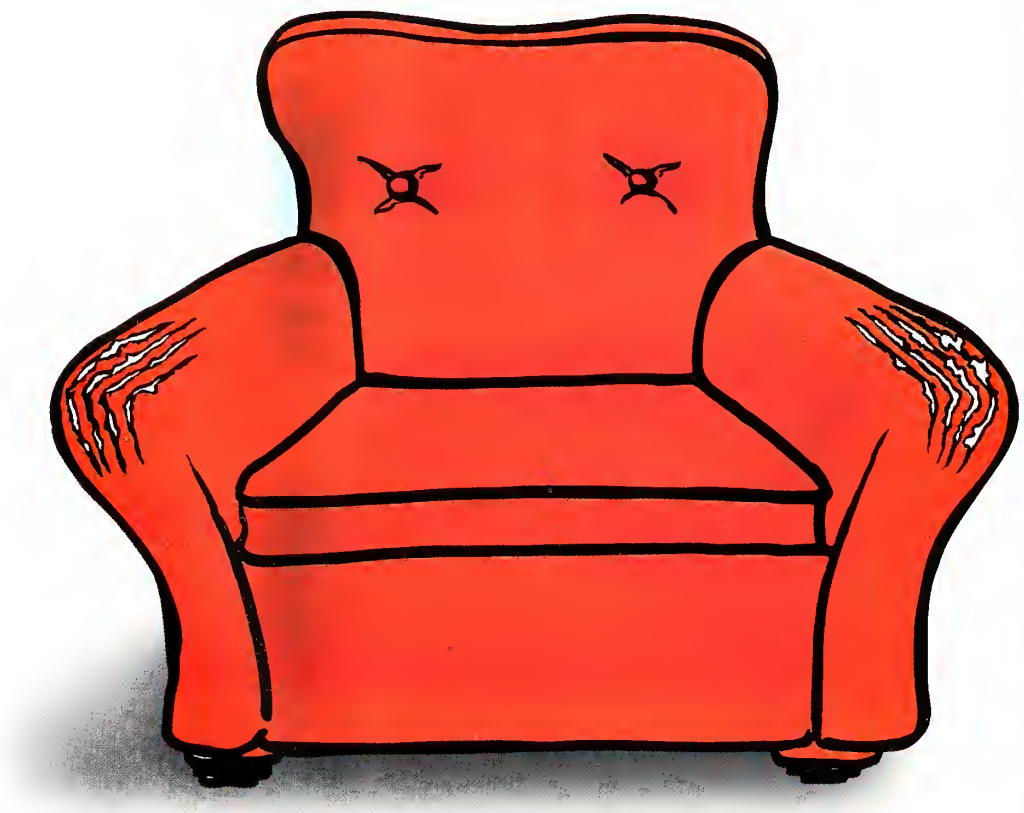
Product information. Nurofen Gel Maximum Strength: Gel for topical administration containing ibuprofen 10%w/w. **Indications:** For the relief of pain and inflammation associated with backache, non-serious arthritic conditions, rheumatic and muscular pain, sprains, strains, sports injuries and neuralgia. **Dosage:** Adults, the elderly and children over 14 years: Squeeze 2 to 5cm of the gel (50 to 125mg ibuprofen) from the tube and lightly rub into the affected area until absorbed. The maximum number of applications of 5cm gel in any 24 hours is four. Wash hands after each application. The dose should not be repeated more frequently than every four hours. Do not exceed the stated dose. Review treatment after 2 weeks, especially if the symptoms worsen or persist. Children under 14 years: Do not use on children under 14 years of age except on the advice of a doctor. **Precautions and Warnings:** Apply with gentle massage only. Avoid contact with eyes, mucous membranes and inflamed or broken skin. Discontinue if rash develops. Hands should be washed immediately after use. Not for use with occlusive dressings. The label will state: Do not exceed the stated dose. Keep out of the reach of children. For external use only. If symptoms persist consult your doctor or pharmacist. Do not use if you are allergic to ibuprofen or any of the ingredients, aspirin or any other painkillers. Consult your doctor before use if you are taking aspirin or any other pain relieving medication, you are pregnant. Not recommended for children under 14 years. **Side Effects:** Hypersensitivity reactions have been reported following treatment with ibuprofen. These may consist of a) non-specific allergic reaction and anaphylaxis, b) respiratory tract reactivity comprising of asthma, aggravated asthma, bronchospasm or dyspnoea, or c) assorted skin disorders, including rashes of various types, pruritis, urticaria, purpura, angiodema and less commonly, bullous dermatoses (including epidermal necrolysis and erythema multiforme). Gastro-intestinal: abdominal pain, dyspepsia. **Product Licence Number:** PL 10972/0082. **Licence Holder:** Goldshield Group PLC (trading style: Goldshield Pharmaceuticals). NLA Tower, 12-16 Addiscombe Road, Croydon CR0 0XT. **Legal Category:** P. **Price:** MRRP £5.25. **Date of preparation:** June 2001. Distributed by Crookes Healthcare Limited, Nottingham, NG2 3AA. NU295.

CROOKES HEALTHCARE

Eumovate Eczema & Dermatitis Cream Product Information.
Presentation: Cream containing clobetasone butyrate 0.05% w/w. **Uses:** Short-term treatment and control of patches of eczema and dermatitis including atopic eczema and primary irritant and allergic dermatitis **Dosage and administration:** Adults and children, aged 12 years and over. Apply sparingly to the affected area twice a day for up to 7 days If the condition improves within 7 days stop treatment If condition does not improve in the first 7 days or becomes worse, or if after 7 days treatment an improvement is seen but further treatment is required, the patient should be advised to consult a doctor To be used in children under 12 years only on the advice of a doctor. **Contraindications:** Known hypersensitivity Broken skin or skin lesions caused by infection with viruses (e g herpes simplex, chicken pox), fungi (e.g candidiasis, tinea) or bacteria (e g impetigo) Acne vulgaris. **Precautions:** Absorption can be increased by occlusion so treatment is limited to no more than 7 days continuous treatment without occlusion. Treatment should not be initiated at the same site for a third time without medical advice Only to be used for the treatment of eczema or dermatitis as other conditions may be masked or exacerbated Should not be used on the face, groins, genitals or between the toes. Medical advice should be sought in seborrhoeic eczema. Consumers should be warned against letting the cream get into the eye, as topical steroids can cause glaucoma. Do not use with other topical corticosteroids or in the treatment of psoriasis. **Pregnancy and lactation:** Use only on the advice of a doctor. **Side effects:** Hypersensitivity. Exacerbation of symptoms. **Legal category:** P **Product licence number:** 10949/0346. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS. **Further information available on request from:** Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Wallis House, Great West Road, Brentford, Middlesex, TW8 9BD. **Package quantity and RSP:** 15 g tube – £5.49 **Date of preparation:** August 2001 Eumovate is a registered trademark of the GlaxoSmithKline Group of Companies

References:
1 Munro DD, Wilson L. Br Med J 1975, **3**: 626-8.
2 Parneix-Spake A, Goustas P, Green R. J Dermatol Treat [In press].

SKIN RAGE?



Before it gets to this, get to them

Skin Flare-Up due to eczema and dermatitis, characterised by itchy, red dry and inflamed skin, can be extremely aggravating. Eumovate Eczema & Dermatitis Cream, available without prescription, acts early and helps break the Itch-Scratch Cycle, before it gets out of control.
No other over-the-counter medicine clears Skin Flare-Up more effectively than Eumovate Eczema & Dermatitis Cream.[1,2]

for Skin Flare-Up

eumovate®
eczema & dermatitis cream
clobetasone butyrate 0.05%

over to you

Negligence case against Boots

A pharmacist who is suing Boots for negligence will have his case heard in the High Court on January 14 after a preliminary hearing in Newcastle last month.

Martin Garfoot was suspended from his job as a Boots branch manager after he was falsely accused of rape by a pharmacist colleague, Lynn Walker, in 1996.

He later sued Mrs Walker for defamation and was awarded £400,000 damages after the jury found unanimously in his favour.

Mr Garfoot is suing Boots for the stress arising from the company's handling of the disciplinary procedure.

Damages will be determined in a separate trial if Mr Garfoot is successful in the liability trial. His solicitor could not comment on the damages being sought.

A Boots spokesman said the company was unable to comment while legal proceedings are underway.

Avoiding DVT on long-haul flights

The Government has advised that women taking oral contraceptives or hormone replacement therapy should discuss the use of anti-embolism stockings with their community pharmacist before going on a long-haul flight.

Those who are pregnant or have recently had a baby should seek advice from the antenatal team or health visitor.

These women, who are at increased risk of travel-related deep vein thrombosis, should carry out recommended exercises during the flight, such as bending and straightening their legs and feet every half an hour.

The latest official advice is that the vast majority of air travellers do not need to take medication to prevent DVT.

While aspirin can help clotting conditions in the arteries, there is no evidence it is effective in preventing travel-related DVT or pulmonary embolism, says the Department of Health.

Groups at high risk of DVT, who should seek medical advice before the trip, are:

- those who have previously suffered DVT or pulmonary embolism
- anyone with thrombophilia or a family history of clotting conditions
- people with cancer or who have had cancer treatment
- those who have undergone major surgery, or had a hip or knee replacement in the past three months
- anyone who has suffered a stroke.

These groups make up 90 per cent of those who are affected by DVT.

Sleeping tablets should be avoided during flights as they increase immobility.

For more information:
www.doh.gov.uk/dvt

DTC found to improve compliance

Direct-to-consumer advertising can improve patient compliance, a new study released by Pfizer Inc claims.

Looking at five medical conditions, the study, conducted by RxRemedy, found that arthritis patients were 75 per cent more likely to stay on their medication if they had been involved in choosing the drug after seeing DTC adverts.

Patients suffering from nasal allergies were twice as likely to continue with their drug regime. The figures for depression, high cholesterol and diabetes were 37 per cent, 16 per cent and 10 per cent respectively.

Meanwhile, the All-Party Pharmacy Group has called on the Government to establish a working group to consider the most appropriate approach of delivering clear, comprehensive medicines information.

Following its meeting on DTC advertising (*see C&D November 10, p9*), the APPG said urgent action was needed. It said it was wrong to exclude the pharmaceutical industry from the discussions and that an all-inclusive approach was likely to be the most productive.

While it was difficult to argue against manufacturers being allowed to provide informed and objective information, the APPG said it was clear that "DTCA is not the best, most objective and informed way to deliver such information to the public".

It recommended kite-marking as the most appropriate approach to developing standards for the quality and reliability of medicines information and said the National Institute for Clinical Excellence should be charged with the task.

For she's a jolly good Fellow...

A *C&D* journalist is among eight new Fellows designated by the Royal Pharmaceutical Society this week.

Contributing editor Adrienne de Mont has been made a Fellow for distinction in the profession of pharmacy. She joined *C&D* in 1973, becoming technical editor and then assistant editor.

On becoming freelance in 1979, she maintained close links with *C&D* while writing for several other professional and consumer publications. Adrienne was a committee member of the Society's East Metropolitan Branch for over 10 years.

Other pharmacists honoured are:

For distinction in the profession and practice of pharmacy

- Alison Blenkinsopp, professor of the practice of pharmacy, Keele University.
- Helen Remington, chief pharmacist, Addenbrooke's NHS Trust, Cambridge, and president, Guild of Healthcare Pharmacists.
- Brian Spencer, agricultural and veterinary pharmacist. For distinction in the science of pharmacy.
- Gary Martin, professor of formulation science, King's College London Department of Pharmacy.

Science and practice

- Dr Stephen Thomas, hospital pharmacist in Cardiff, with specialist interest in wound management. Member of the British Pharmacopoeia Committee (Surgical Dressings and Sutures).

Practice

- Dr Thomas Duffy, founder and senior partner, Lowden International.

Profession

- Charles Morecroft, community pharmacist in Derbyshire, who is involved in the Society's Listening Friends scheme.

Adrienne de Mont: honoured for distinction in the pharmacy profession

Counter fraud

The NHS Counter Fraud Service has exceeded its target for agreed recoveries from contractors for 2001-02. At the end of October it had collected a total of £7.47 million, health minister Hazel Blears said in a House of Commons written answer. A public service agreement to reduce patient prescription charge fraud by 50 per cent by April 2003 is also on target.

Parallel imports set to rise by 120pc by 2006

Price fluctuations, cost-containment policies and variations in the exchange rates are likely to drive up the value of parallel imports in Europe by 120 per cent to $7.4 billion (£5.21 billion) over the next five years, *Reuters Business Insight* estimates.

The market value for the current year is $3.3bn (£2.3bn), a sum which Germany alone is expected to exceed by 2006. The UK parallel trade market this year is worth around $999 million (£697m). By 2006 the UK and Dutch markets are estimated to rise to a collective total of $3bn (£2.1bn).

The researchers believe that the parallel import market will be fuelled by legal victories over manufacturers' attempts to stifle the practice through increasingly aggressive strategies.

These include price dumping, dual pricing, discounting, supply restrictions and changes to product specifications.

Only last week a complaint was filed with the European Commission against Pfizer SA by the European Association of Euro-Pharmaceutical Companies (EAEPC) regarding the company's dual pricing policy in Spain.

Reuters also believes that parallel traders will increasingly target innovative, high-priced products as well as new, high volume generics.

The report, *The Global Parallel Trade Outlook 2001-2006*, states that increased penetration into the generics market could be particularly profitable due to an increased trend towards generic substitution in EU member states.

In light of the imminent patent expiry of 18 of the world's biggest selling medicines, Reuters says that "parallel traders should view this opportunity as a gold rush".

The researchers also warn that EU enlargement is likely to increase the pressure on innovative companies. New member states, whose accession treaty does not include a clause guaranteeing free trade principles, could become new PI markets.

The researchers also detect signs that parallel trade, which had traditionally been confined to the EU, is now taking a foothold in South Africa, India, Russia and the Philippines.

For more information:

www.reutersbusinessinsight.com
Tel: 0207 675 0990
Price :£595 (paper), £745 (PDF)
Reuters Business Insight

RETAILING

Pharmacy sales rally

Pharmacy sales growth has rallied in November, the Confederation of British Industry's *Distributive Trades Survey* has revealed.

Forty four per cent of pharmacists said that sales had improved, while only 16 per cent said sales had dropped.

The resulting balance of plus 28 is a considerable improvement on figures for October, when the balance was 22.

The majority of pharmacists questioned felt that sales were average for the time of year. A further 18 per cent stated that the volume of sales was good, while 16 per cent felt sales were disappointing.

The retail sector in general reflected this positive trend, with half of all retailers saying that sales volumes had risen. Twenty per cent stated the opposite. The trend is expected to continue into December.

RETAILING

Body Shop brings genetic testing to the high street

The Body Shop has become the first high street retailer to offer a genetic test aimed at identifying the body's needs, food intolerances and appropriate dietary choices.

The test, known as *You and your genes*, will be available in 11 Body Shop branches in London (3), Leeds (2), Birmingham, Glasgow, Edinburgh, Nottingham, Milton Keynes and the Bluewater shopping centre.

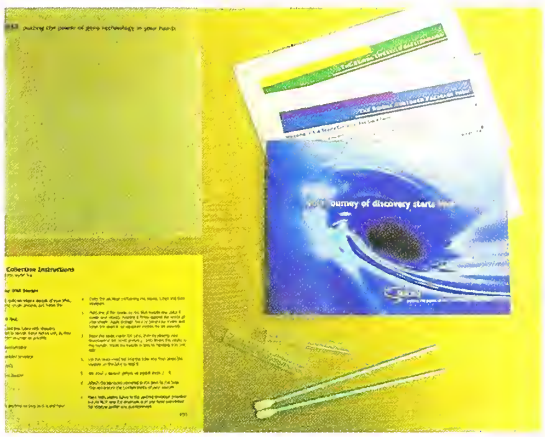
The £120 testing kit includes a brush used to take a buccal swap and a lifestyle questionnaire. Both are sent to the maker of the testing kit, Sciona Limited.

Within three weeks patients will receive a 40 page report, including an impact analysis of the patient's current diet and a list of foods to be avoided.

The report will also give advice on how to implement the results and change the diet.

For more information:

www.sciona.com; www.the body-shop.com
Price: £120



The *You and your genes* testing kit and report, available from selected branches of Body Shop

FINANCE

Wellcome Trust reduces historic link with GSK

The Wellcome Trust has significantly reduced its historic link with GlaxoSmithKline (GSK) after selling 100 million GSK shares at £17.80 each.

GSK itself bought more than half of the shares (56 per cent) as part of the company's share buy-back scheme *(see C&D November 3, p10)*. The remaining shares were placed with institutions.

The move is the latest step in reducing the dependency of the Trust's investment portfolio on its founder stock. The Trust's said that the move was designed to mitigate the risks of investment by diversifying the portfolio across a large number of asset classes.

Before the share sell-off a quarter of the Trust's shares were GlaxoSmithKine shares. This has now been reduced to less than 10 per cent.

The Trust's stake in GSK is now just 1 per cent compared with a 40 per cent ownership of Wellcome prior to its merger with Glaxo in 1995.

New ABPI President: Dr John Patterson, AstraZeneca's executive vice president (product, strategy and licensing) has been named as the next president of the Association of the British Pharmaceutical Industry. Dr Patterson will succeed Novartis' chairman, Bill Fullagar, in April 2002

POLICY

HAs given deadline to find funds for NICE guidance

Health authorities and primary care trusts will have three months to provide funding for medicines approved by the National Institute for Clinical Excellence under new orders announced by Health Minister Lord Hunt this week.

The implementation of Labour's election promise to make recommendations by NICE compulsory has led to an outcry from health managers, who say that it will mean cuts elsewhere in their budgets.

However, it has been welcomed by British Medical Association chairman Ian Bogle who said doctors had long been opposed to post code prescribing.

The news came the day before Alan Milburn, the Health Secretary, announced the annual allocations of funds to HAs and PCTs, including increases from the extra £1bn announced for the NHS by the Chancellor, Gordon Brown, in his pre-budget report.

The new rules making NICE recommendations compulsory will apply from January 1, 2002. From that date, clinical decisions made by doctors involving NICE recommended treatments must be funded within three months of NICE issuing a technology appraisal guidance (TAG).

"The obligation is intended to fall principally on HAs and PCTs to ensure that they properly manage the money in their general allocations. This places a clear onus on all those managing budgets to collaborate so that patients can be guaranteed that if a treatment recommended by NICE is appropriate for them, they will receive it," said Lord Hunt on Wednesday.

HAs and PCTs will be expected to meet the costs out of their general allocations. The statutory directions apply only to TAGs in England.

The National Assembly for Wales is responsible for similar arrangements in Wales.

ETP pilot starts

The wholesaler-led TranScript consortium has officially begun its electronic transfer of prescription pilot with the installation of its software in one pharmacy and one GP surgery in the East Hamphsire area. A gradual roll out is expected over the next three months.

New distributor

From January 2 2002 Aventis Pharma's OTC-products will be sold and distributed by Chemist Brokers. Aventis Pharma will cease to distribute the products with the scheduled delivery during the week commencing December 17. From December 24 all orders should be placed with Chemist Brokers.

For more information:
Tel: 0239 222 2500 (Chemist Brokers).

ComingEvents

DECEMBER 10
Nottinghamshire Branch, RPSGB
The Royal Pharmaceutical Society's New Code of Ethics, by Professor Joy Wingfield, Pharmacy School, University of Nottingham.

DECEMBER 11
Moray & Banff Branch, RPSGB
PPD Edinburgh: Helping them to Help Us, by Lorna Ramage at the Laichmoray Hotel, Elgin, 7pm.

NICPPET
Wound Management, at the Ramada Hotel, Belfast, 10am -5pm.

DECEMBER 13
Glasgow Branch, RPSGB
Christmas Social – Treading the Grapes, at the Western Infirmary private dining room, 7.30pm.

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More importantly, there is no more effective form of NRT than Nicorette Gum.[1]

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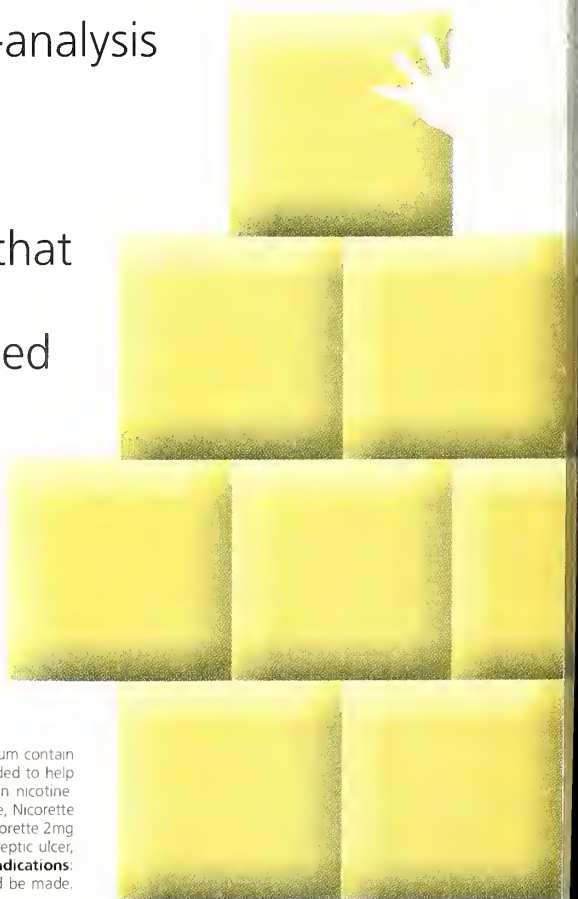

Nicorette Gum Abbreviated Prescribing Information. Presentation: Nicorette 4mg gum and Nicorette 2mg gum contain 4mg and 2mg of nicotine respectively in a chewing gum base. Original, Citrus or Mint flavour **Indications:** Intended to help smokers who want to give up smoking but who experience difficulty in doing so owing to their dependence on nicotine **Dosage & Administration:** Each piece should be chewed slowly for 30 minutes. After 3 months ad libitum dosage, Nicorette gum should be gradually withdrawn. Maximum recommended daily dose: Nicorette 4mg gum: 15 x 4mg pieces. Nicorette 2mg gum: 15 x 2mg pieces. Not to be used by people under age 18 unless recommended by a doctor. **Precautions:** Peptic ulcer, angina pectoris, recent myocardial infarction, serious cardiac arrythmias, systemic hypertension, gastritis. **Contra-indications:** Pregnancy & Lactation. If the patient cannot give-up smoking without NRT then a risk benefit assessment should be made.

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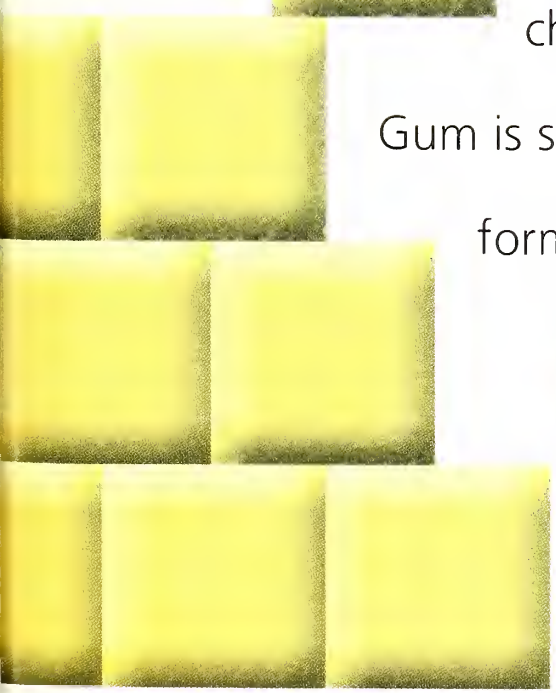

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Special Warnings: Rarely dependence. **Adverse Effects**: *Gums*: Occasional hiccups, indigestion, hyper-salivation, throat irritation, allergy, mouth ulcers. **Pharmaceutical Precautions**: Store below 25°C. **Legal Category**: *Nicorette 2mg gum & Nicorette 4mg gum*, GSL. **Package Quantities & Cost** (all trade prices correct at time of printing): *Gum*: boxes of 15 pieces, 30 pieces and 105 pieces, in blister strips of 15 pieces. Nicorette 4mg gum (PL00032/0249) (£2.11) (15), (£3.99) (30), (£10.83) (105) Nicorette 2mg gum (PL00032/0248) (£1.71) (15), (£3.25) (30), (£8.89) (105). **PL Holders**: Pharmacia Limited, Davy Avenue, Milton Keynes, MK5 8PH, UK. Tel: 01908 661101. **Date of preparation**: November 2001. **References. 1**. Silagy C et al. Nicotine replacement therapy for smoking cessation (Cochrane Review). In: The Cochrane Library, 2001, Issue 2. 1999. **2**. Data on file. **3**. IMS Pharmatrend.

Comment from the Editor

As the uncertainty over how the Government intends to reimburse pharmacies for the generic medicines they buy on behalf of the NHS continues, suppliers are warning that product shortages are once again a real threat. The incoming BGMA chairman, John Beighton, says that only by making the UK a more attractive market can a recurrence of the events of 1999 be prevented *(see p39)*.

While generic companies can look forward to the patent expiry of 18 high-volume products in the months ahead – more than in the past decade – price pressures have led to product ranges being streamlined. This, allied to a more international outlook by manufacturers, appears to be the name of the game. And competition is likely to further intensify if, as *Reuters Business* suggests *(p12)*, parallel traders are increasingly elbowing into the generics market.

One thing is certain – the percentage of prescriptions written for generics is set to increase yet further as the number of new branded pharmaceuticals launched for mainstream use declines. But the Government's proposed reimbursement for generics does not mention a margin for pharmacists. The DoH position is that pharmacists should be reimbursed as closely as possible to what they actually pay. It is all very well for Mr McKeon to tell pharmacists to focus on the opportunities before them, when the margin on generics is a major contributor in keeping their business viable.

The warm words regularly doled out to pharmacists by the DoH are at odds with the actions it takes. Will the outcome of its generics inquiry be more of the same? And what are pharmacists to make of the argument that the Department currently spends so little on running the existing system that an increase in the administrative expenditure is justified?

Parallel traders are increasingly elbowing their way into the generics market...

Yourviews

PSNC's Godfrey Horridge says pharmacies face the largest fall in gross profit for seven years

Contractors see the cost of imposition

The harsh imposition by the Department of Health of a 3.7 per cent increase in the global sum, subject to an £8.1 million recovery of overpayment for 2000-01 and a prescription volume increase of 6 per cent, will have a significant effect on pharmacy profitability.

In addition, the drugs budget is forecast to rise by 10.3 per cent in 2001-02 compared with only 3.7 per cent in 2000-01.

The annual statistics on pharmacy profitability in England and Wales, which are a consolidation of all contractors' FP34 statements, are expected to show the largest fall in percentage gross profit for seven years.

The detailed figures are set out in columns 1 and 2 of the table *(right)*. The main reasons for the fall are the 5.43p drop in income per prescription coupled with the 39.38p rise in the basic ingredient cost per script.

Within the figures for 2001-02 there is a major difference between the April to October period, when the 97.5p dispensing fee was paid, and the November to March 2002 period when the 10.1p fee reduction will be imposed *(see columns 3 and 4)*.

The forecast gross profit percentages are 12.9 per cent for the first seven months and only 12.1 per cent for November 2001 to March 2002.

The forecasts are all based on national averages. Contractors with ingredient costs per item or script volumes above or below the national average will obviously have different gross profit percentages. However, the trends will hit all contractors.

A graphic illustration of the script volume growth we are facing will appear on the PSNC website in the next few days when the May 2001 NHS Prescription and Remuneration statistics are published.

These will show that the 50 million prescriptions per month barrier has been broken for the first time, with 50.5m items being dispensed in England and Wales in May 2001.

Pharmacy profitability in 2001-02

	2000-01 Actual Pence per Rx	2001-02 Forecast Pence per Rx	April to Nov 01 Pence per Rx	Nov 01 March 02 Pence per Rx
Basic ingredient cost	969.21	1008.59	1006.41	1011.52
Less discount	(97.17)	(103.06)	(101.46)	(105.23)
Container allowance	5.67	4.00	4.00	4.00
Cost of sales	877.71	909.53	908.95	910.29
Fees	103.32	99.04	103.25	93.36
Expensive Rx allowance	1.91	1.98	1.98	1.98
Professional allowance	30.96	29.74	29.74	29.74
Gross profit	136.19	130.76	134.97	125.08
Total payment per Rx	1013.90	1040.29	1043.92	1035.37
Gross profit %	13.4%	12.6%	12.9%	12.1%

HOSPITAL REPORT

More tax – or less VAT avoidance?

Tony Blair has hinted that everyone will be paying more tax to save the NHS, but the Government might do better by clamping down on NHS trusts that are involved in VAT avoidance.

Some companies are telling trusts that if they buy directly, rather than via a wholesaler, they need not pay VAT. The VAT "saved" can then be split between the supplier and the trust.

It appears this is legal, provided that the company supplies direct to the patient. The companies promise a "comprehensive service". However, if there are any problems the patient is usually referred back to the NHS.

So what supplies are being made in this way? Parenteral nutrition is one example. NHS production units cannot match the VAT-free cost. Erythropoetin is another; out-patient HIV drugs another.

"If less money is being raised by the Treasury, there will be less going to trusts"

Why is this a problem, if NHS trusts are saving money? Quite simply, VAT goes to the Treasury and if less money is being raised by the Treasury, there will be less going to trusts. This is why trusts were instructed some years ago not to use such schemes.

Another effect of such schemes is that the number of hospital production units has been reduced. Some of their products were important, but did not have a long enough shelf life to be commercially marketable.

So rather than taxing us all a little bit more, Mr Blair, how about stopping this practice of cherry picking? Or should we set up Hospitalpharm UK plc to reap the same benefits as the companies and save all that VAT?

Written by a senior hospital pharmacist

TOPICAL REFLECTIONS

Putting theory into practice isn't always easy

I am the first to admit that I find continuing professional development difficult to apply. The clinical information provided is all very well, but subjects that can be applied immediately in practice seem few and far between.

The various training systems for the OTC supply of emergency hormonal contraception were an exception. I enjoyed the courses and have since regularly applied their lessons to the point where I sometimes think I now sound like a tape recorder. EHC is an example of knowledge being applied, and applied appropriately.

Now, *C&D* has now come up trumps with its Pharmacy Business Excellence course, sponsored by Crookes Healthcare. Here is a well-written and highly relevant exposure of the everyday things I should be doing in my business, but always put off. And also very timely, as last week's cut in the NHS prescription fee is a sharp reminder that I cannot afford to ignore the private side of my business.

I have already completed Module 1 and started to apply its lessons. Not only should I see a real return for my efforts but for each completed module I also earn 1.5 hours CPP accreditation. Now that's the type of CPD I can profit from.

Boots has its niche and I have mine...

All commercial companies have to adapt to market pressures in order to prosper and Boots is no exception. Its Wellbeing initiative is a reaction to that pressure and as the company discards the "odds and sods" in favour of health-related services the result is a more professional look *(C&D December 1, p36)*.

Whether the more professional approach will result in Boots establishing a profitable niche remains to be seen but what is interesting is the public perception of what comprises community pharmacy. The danger of the Boots approach is that the pharmacy will be subsumed by the "Wellbeing" concept and I still consider that the community pharmacy should be seen as a single dominant entity.

But Boots (or other multiple companies) do not see pharmacy as a personal profession where the development of the individual professional is as important as the development of the service that each individual is able to provide. To them the scope and quality of service is defined and then divorced from the personality of the individual providing that service.

In my independent community pharmacy the reverse is true. While I can learn from Boots in the application of professionalism to front shop activities, my most important asset is myself. I have built up my "family pharmacy practice" over time and most of my customers treat me as "their pharmacist". I wish Boots every success with its Wellbeing venture, but it is not an approach I have any desire to emulate.

Nothing like a mug...

Over the years the pressure of business has meant that tea, coffee and lunch breaks have become a novel concept. As a result, regular cups of tea and coffee, loyally supplied by Dotty, are either consumed cold or poured wastefully down the sink and so far I have been unable to overcome this problem, that is until the recent intervention of Pfizer Consumer Healthcare.

As part of its marketing campaign for Benylin Active I was presented by its representative with a handsome stainless steel insulated mug complete with lid. The liquid contents stay piping hot almost indefinitely and as an added bonus the tea no longer resembles soup. The capacity is so large that the cup acts as its own teapot. One tea bag suitably infused provides me a hot cauldron of tea to sip and enjoy at my leisure while in between I even find time for dispensing!


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Our Consumer Healthcare salesforce, for instance, is the largest in the industry. With premium merchandising expertise, pharmacy training and dedicated customer services, they can add real value to your pharmacy.

And for those times when you need instant access to product information, we've created a pharmacy helpline. Simply ask your Territory Business Manager or call 0500 [illegible] one of our professional, fully trained staff will be available to answer all your [illegible]

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The Royal Pharmaceutical Society in Scotland and the British Society for the History of Pharmacy held a joint meeting at York Place, Edinburgh as part of the sesquicentenary celebrations of the RPSiS. The speaker, Mr SWF Holloway, outlined the early history of the profession in Scotland. Mr Holloway, left, is welcomed to York Place by Dr Peter Worling, chairman of the BSHP

NHS SEMINAR

NHS wastes £9bn a year...

Wasteful prescribing, clinical negligence, drug errors and theft all contribute towards the NHS losing between £7-9 billion each year as a result of poor management systems, according to Stuart Emslie, the NHS' head of Controls Assurance.

The NHS must eradicate the culture of blame that exists within it and implement better risk management systems to ensure that those who work in the NHS can provide a more efficient service and reduce waste.

This was the message given by Mr Emslie to delegates at a *Drug and Therapeutics Bulletin* seminar held in London recently.

He suggests that lack of training, poor communication, lack of competency and supervision, and distraction are all contributory factors towards the NHS wasting such large amounts of money *(see table, below right)*.

Mr Emslie said the principles of corporate governance had to be applied to the NHS. Every primary care trust will need to set up a system of internal controls to reduce the risk of failing to meet their objectives.

Companies such as Marks & Spencer spend about 18-20 per cent of turnover on management, whereas the NHS spends 3- 4 per cent, which is "ludicrous" said Mr Emslie. "It costs us a lot of money not to manage the NHS."

... including prescriptions

Why do doctors prescribe in individual consultations when it is not clinically indicated? Dr Marjorie Weiss, University of Bristol, suggested that:

- it is a way of concluding a consultation
- it forestalls any discussion
- a doctor may not be in the mood for any discussion due to stress
- prescribing conveys an impression that diagnosis is more precise than it actually is.

Although this adds to prescribing budgets, doctors argue that it helps to maintain the future relationship with the patient.

Professor Colin Bradley from the University of Cork called for doctors to be more open and honest with patients. He said that when it came to dealing with demanding patients, doctors would benefit by having better negotiating skills rather than longer appointments.

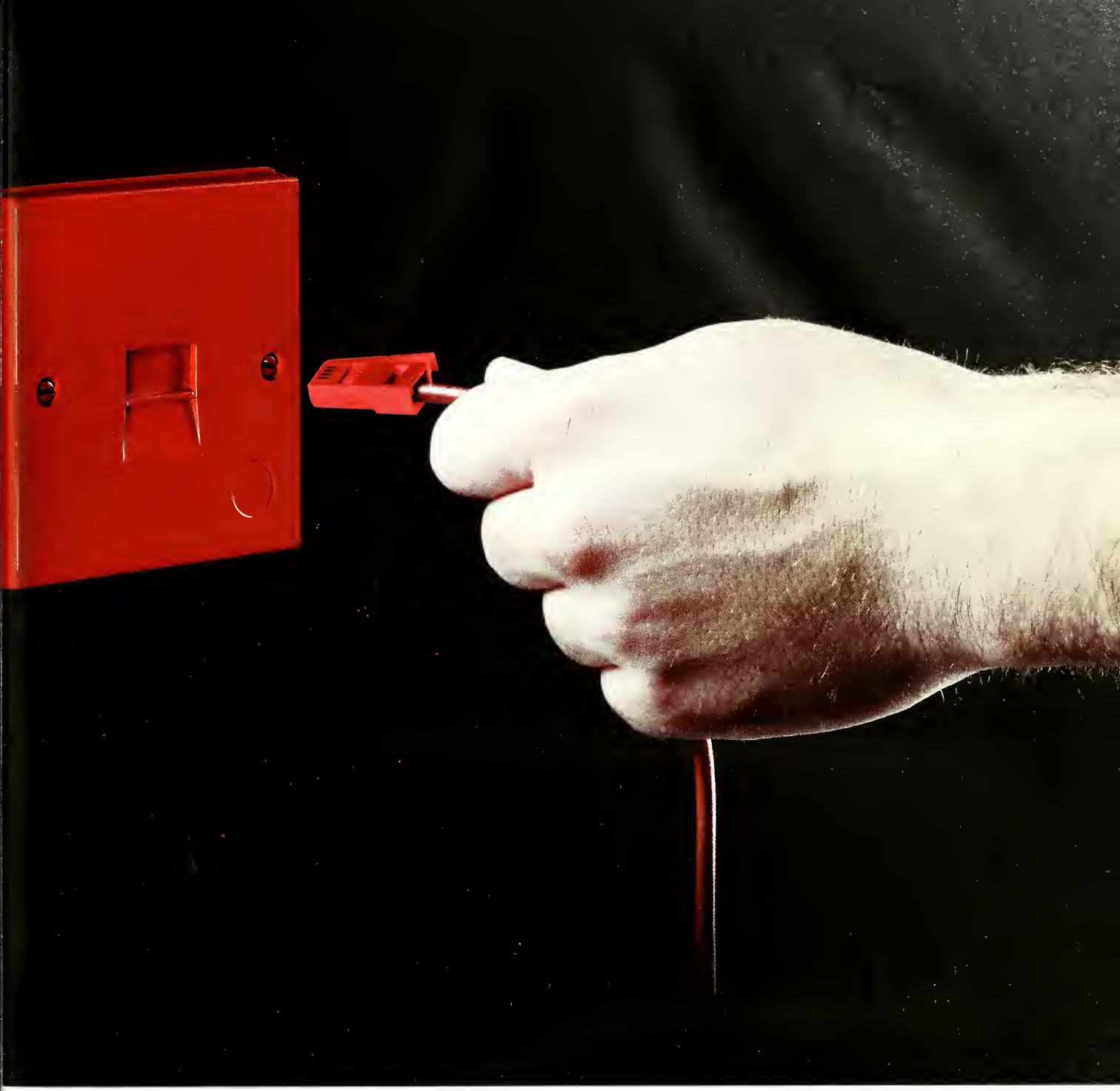
Professor Hugh McGavock, University of Ulster, said there was a need to update GPs in clinical areas that were relevant to general practice. He suggested that the best way forward might be for doctors and pharmacists to form therapeutic partnerships. "The door is wide open, you don't have to push it," was his message.

Pharmacists looking to the future in terms of prescribing can draw analogies from nurses. Professor Veronica James, head of the School of Nursing at Nottingham University, showed that in the USA, nurse prescribing had not caused an increase in budgets or litigation.

Nurses who prescribe tend to do so in single specialist areas, eg dermatology, she said. Also nurses were well versed in being accountable and were keen to forge links with pharmacists and doctors.

Where the NHS loses money

- Adverse patient events (prolonged stay in hospitals): £2 billion
- Sickness absence: £2b
- Crime/fraud: £1-3b
- Hospital acquired infection: £1b
- Drug errors: £300-£600m
- Wasteful prescribing: £300-£600m
- Clinical negligence: £400m (potential liabilities: £2.4b)
- Malnutrition: £230m
- Occupational health and safety: £150m
- Avoidable management and legal costs: £100m
- Overall loss of £7-9b (16 to 20 per cent of total budget).



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Growth's false dawn?

Most business analysts agree that the UK is better placed than most of its European partners to withstand the buffeting resulting from the slowdown in the world economy and the September 11 attacks.

Certainly the 0.6 per cent increase in GDP between the second and third quarters of this year was stronger than expected.

But not all observers concur with the Chancellor's prediction that growth next year will be only marginally slower than had been expected six months ago.

Nor is there a widespread belief that the Government's raising of its earlier forecast for 2003 growth, to between 2.75 per cent and 3.25 per cent, is justified on present evidence.

The resilience of consumer spending – which, in the absence of a surprise rebound in manufacturing, will remain the principal engine of economic as well as retail growth – is starting to show signs of weakness.

Confidence fell sharply in October, as jitters over job prospects began to surface.

Official estimates show that annual growth of household spending held steady in value terms during the third quarter of this year, (at 6 per cent), after having slowed to 1.5 per cent between the two latest quarters. Without the effect of higher prices, these figures translate into year-on-year volume growth of 4.5 per cent, and a quarter-on-quarter increase of 1.3 per cent.

Evidence from the high street also points to weakening consumer confidence. The CBI says that sales volume growth overall in September was the slowest this year, and the least buoyant since December 2000.

After strong annual increases in sales through the summer, pharmacists saw demand soften in September; in October, only one in five businesses achieved year-on-year growth.

Government estimates indicate a 0.1 per cent decline in total retail sales volumes in October, giving a 5.7 per cent increase over the year, compared with a 6.0 per cent rise in the 12 months to September.

Meanwhile, the average high street price of pharmacy goods during October was 0.7 per cent higher than 12 months earlier, while retail prices overall rose by 1.6 per cent.

In the three months to October retail price inflation averaged 1.8 per cent, compared with 0.4 per cent for pharmacy goods.

Price inflation remains subdued throughout the supply chain, with factory gate prices down 0.6 per cent in the year to October, while costs of materials and fuel fell 9.0 per cent.

Manufacturers' prices for pharmaceutical preparations increased by 2.1 per cent in the first 10 months of this year, and in October were 1.9 per cent higher than a year before. Factory gate prices of perfumes and toiletries increased 0.6 per cent in the period January to October, to end at a level 0.5 per cent up on the year.

In contrast to most sectors of manufacturing, the pharmaceutical industry benefited from a buoyant demand in the third quarter, with total domestic and overseas sales up over 11 per cent, to a figure 21 per cent higher than a year earlier. Perfume and toiletry manufacturers achieved a modest increase of 3 per cent over the year.

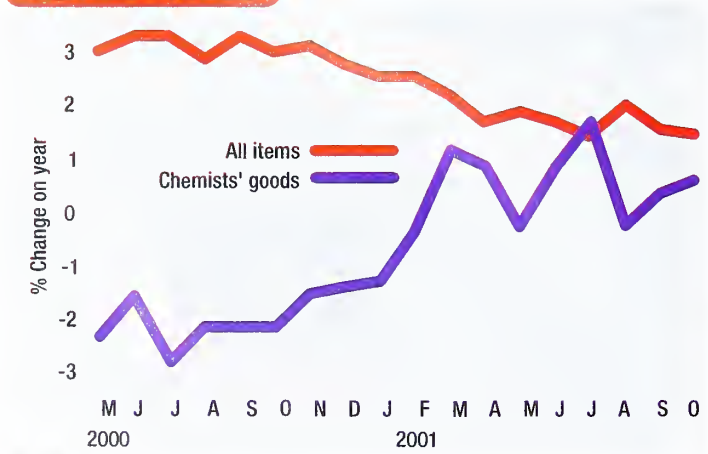
Looking to future spending growth, the latest joint prediction by Oxford Economic Forecasting and the London Business School is that annual household expenditure growth will slow from 3.8 per cent in 2001, to 2.7 per cent and 2.8 per cent in 2002 and 2003 respectively. Retail price inflation is forecast to rise by 1.6 per cent next year and by 2.9 per cent in 2003.

BUSINESS STATISTICS

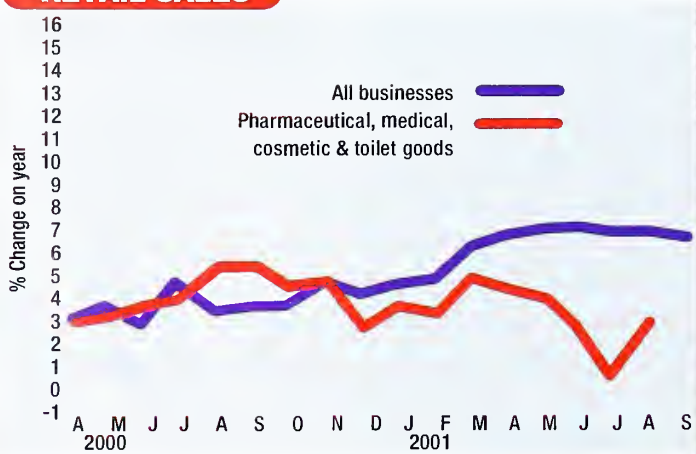
	Latest		% change on previous period	%change on previous three periods	%change on year
PRICES AND COSTS					
Retail prices (Jul 1987 = 100)					
All items	Oct		-0.2	0.6	1.6
Chemist's goods	Oct		-0.2	0.4	0.7
Producer prices (1990 = 100)					
Manufacturing industry, excl food, etc	Oct		0.0	0.0	-0.1
Chemical industry	Oct		0.0	-0.1	0.3
Pharmaceuticals	Oct		0.1	0.7	1.9
Perfumes & toilet preps	Oct		0.5	0.1	0.5
Lip & eye make-up preps	Oct		1.3	1.3	3.9
Dental & oral hygiene preps	Oct		0.0	0.0	-0.1
Shaving preps, deodorants	Oct		0.0	-1.5	-1.0
Adhesive dressings	Oct		0.0	4.1	20.3
AVERAGE EARNINGS (JUL 1990 = 100)					
Whole economy	Sep		-0.2	-1.2	4.4
Chemicals, chemical products	Sep		-0.1	0.9	5.0
OUTPUT (1990 = 100)					
Chemicals, man-made fibres	Q3		1.7	1.0	3.9
Pharmaceutical products	Q3		11.1	15..7	21.2
Perfumes, cosmetics, toiletries	Q3		-8.2	2.0	3.3
SALES					
Consumer expenditure (constant prices)					
Total, £bn	Q3		1.3	3.7	4.5
Retail sales (current prices)					
All retail businesses	Oct		-0.1	0.7	6.0
Pharmaceuticals, toiletries, cosmetics	Sep		-2.4	0.0	6.2
OTHER BUSINESS INDICATORS					
Consumer credit –					
Gross lending (£m)	Sep		2.2	2.9	15.0
Unemployment claimant rate ('000)	Oct		3.2	0.0	-8.6
unemployment claimant count (%)	Oct		0.5	-0.1	-9.1

Sources: National Statistics, Bank of England and *C&D*

RETAIL PRICES



RETAIL SALES



Always read the label

PROFITS RIPE FOR THE PICKING

Here's a tasty little earner, Olbas pastilles are now available in blackcurrant flavour too. Stock up and watch your sales grow

- **Olbas is the No.1 selling inhalant decongestant**
- **Tasty new flavour sure to prove popular**
- **Sugar-free formula and handy-size pack especially designed to meet the demands of today's consumer**
- **£1.5 million brand support**

Leaders in Herbal Medicines
Lanes

www.olbas.co.uk

PLUS codeine

PLUS pharmacy-strength

PLUS Nurofen, the No1 name in pain relief[1]

A huge plus for your pharmacy

Product information. Nurofen Plus: Each tablet contains 200mg ibuprofen Ph Eur and 12.8mg Codeine Phosphate Ph Eur. **Indications:** For the relief of pain in such conditions as rheumatic and muscular pain, backache, neuralgia, migraine, headache, dental pain, dysmenorrhoea, feverishness, symptoms of colds and influenza. **Dosage and Administration:** Adults and Children over 12 years: one or two tablets every four to six hours. Do not take more than 6 tablets in 24 hours. Not for use by children under 12 years of age. **Elderly:** No special dosage modifications are required unless renal or hepatic function is impaired, in which case dosage should be assessed individually. **Contraindications:** Patients with existing, or a history of, peptic ulceration. Hypersensitivity to any of the constituents, aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs). Patients with a history of bronchospasm, rhinitis, urticaria, associated with aspirin or other NSAIDs. Hypersensitivity to codeine, respiratory depression, chronic constipation. **Precautions and Warnings:** Caution is required in patients with renal, cardiac or hepatic impairment. In patients with renal impairment, renal function should be monitored since it may deteriorate following the use of NSAID. Bronchospasm may be precipitated in patients suffering from, or with a previous history of, bronchial asthma or allergic disease. The elderly are at an increased risk of consequence of adverse reactions. Undesirable effects may be minimised by using the minimum effective dose for the shortest possible duration. Should be used in caution in patients with hypotension and/or hypothyroidism. The tablets should be used in caution in patients with raised intracranial pressure or head injury. The label states: Do not use if you have a stomach ulcer or are allergic to ibuprofen (or any of the ingredients of the product) or aspirin. If you are allergic to or are taking any other painkiller, pregnant, or suffer from asthma, speak to your doctor before taking Nurofen Plus. Do not exceed the stated dose, keep out of the reach of children, if symptoms persist consult your doctor. **Side Effects:** Hypersensitivity reactions have been reported following treatment with ibuprofen. These may consist of (a) non-specific allergic reaction and anaphylaxis, (b) respiratory trac reactivity comprising of asthma, aggravated asthma, bronchospasr or dyspnoea, or (c) assorted skin disorders, including rashes c various types, pruritis, urticaria, purpura, angiodema and, more rarel bullous dermatoses (including epidermal necrolysis and erythem multiforme). Gastro-intestinal - abdominal pain, nausea an dyspepsia. Occasionally peptic ulcer and gastro-intestinal bleedin Renal - papillary necrosis which can lead to renal failure. Others hepatic dysfunction, headache, dizziness, hearing disturbance. Rarel thrombocytopenia. Side effects of codeine include constipatio respiratory depression, cough suppression, nausea and drowsines **Product Licence Number:** PL 0327/0082 **Licence Holder:** Crooke Healthcare Limited, Nottingham NG2 3AA. **Legal Category:** **Price:** MRRP: 12's: £2.45, 24's: £4.65, 48's: £8.15, 72's: £9.9 **Date of Preparation:** October 2001.
Reference: 1. I.R. data MAT March 2001 Value and Volume. NFN 341

CROOKES HEALTHCARE

Continuing her Body Basics series, *Fawz Farhan*, visiting lecturer in pharmacy at King's College, London, explains how nutrients are metabolised by the body

Food for thought

- To understand how energy is released from nutrients
- To understand the different processes involved in carbohydrate, fat and protein metabolism
- To understand how energy is stored
- To be aware of basal energy requirements

Nutrients are absorbed from the gut into the bloodstream and lymph following digestion and are then taken up by the cells of the body. There they undergo a series of chemical reactions referred to as metabolism.

Metabolism can be divided into anabolic (synthesis) reactions and catabolic (breakdown) reactions. These drive the cellular activities that control energy consumption, cell function, growth and excretion.

Anabolism

This is a synthesis reaction that leads to smaller molecules joining together to form larger ones. The reaction is fuelled by energy released from cellular adenosine triphosphate (ATP) and is catalysed by enzymes. Examples of anabolic reactions include the synthesis of proteins from amino acids, glycogen from glucose and triglycerides from fatty acids.

Anabolism is the mechanism involved in tissue growth and repair and when nutrients are stored in the liver and fatty tissues.

Catabolism

Large molecules are broken down into smaller ones, accompanied by the release of energy. The main catabolic reaction is oxidation.

An example of catabolism is when glycogen is broken down in the liver to release glucose into the bloodstream. Digestion is also a form of catabolism, although in this case the reaction occurs outside cells.

Cellular respiration

Cellular respiration refers to a series of reactions occurring in cells, which release energy from nutrients.

Two phases are involved:

Anaerobic phase

Glycolysis, the breakdown of glucose, occurs in the cellular cytoplasm and does not require oxygen. The reaction produces pyruvic acid and energy in the form of two ATP molecules.

Pyruvic acid is further metabolised in the aerobic phase. However, under anaerobic conditions in muscle cells, pyruvic acid is first converted to lactic acid where it accumulates until normal oxygen levels return.

Aerobic phase

The anaerobic phase does not produce enough energy for the body to function as it results only in partial glycolysis. Aerobic cellular respiration, which involves the oxidation of glucose by the cell's mitochondria, results in the complete breakdown of glucose to produce 34-36 ATP molecules plus the byproducts water and carbon dioxide. Carbon dioxide is transported to the lungs for elimination.

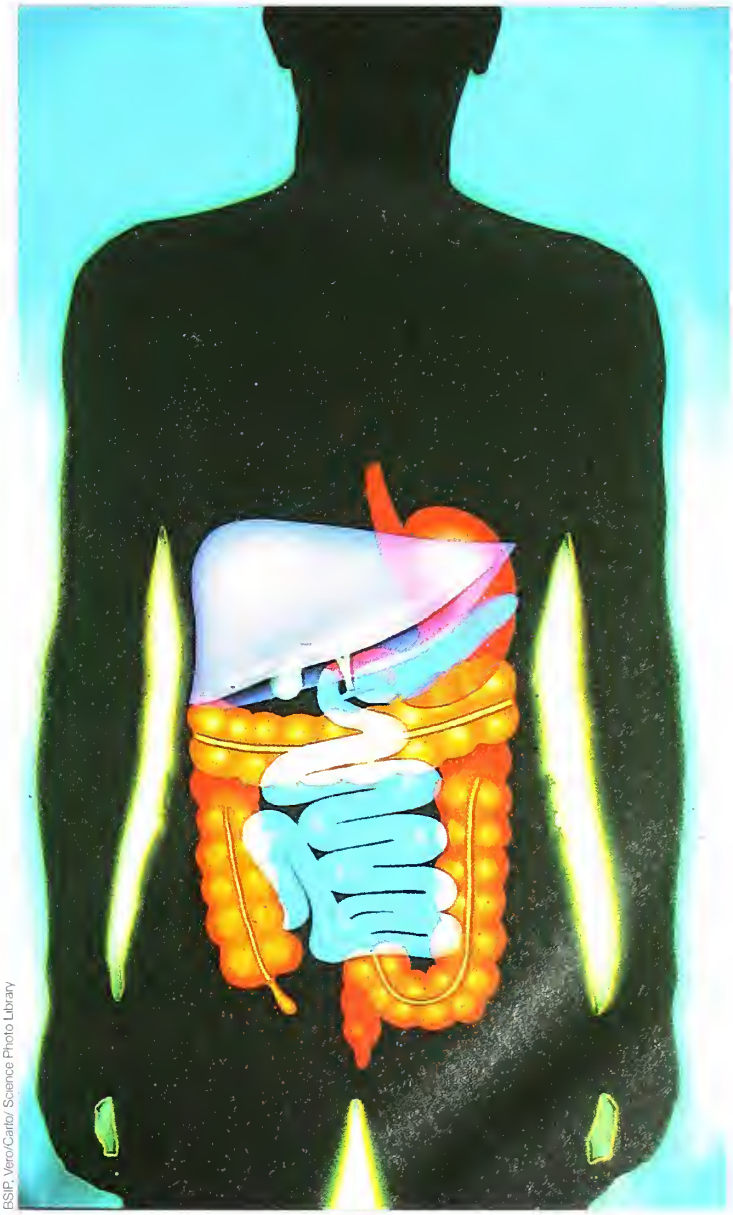
ATP allows the body to store energy for use later when needed. However, during metabolic oxidation some of the energy is released as heat, which is used to maintain body temperature.

Carbohydrate metabolism

The liver is an important metabolic organ as it is involved in the uptake and release of nutrients including glucose.

Glucose molecules enter the

Continued on page 26 ▶



BSIP, Veron/Carlo/ Science Photo Library

The human digestive system on a silhouette of a human figure. Food enters the stomach, which stores and churns it up ready for digestion in the small intestine

Continued from page 25

hepatic cells where they are converted into glucose-6-phosphate. This form of glucose cannot escape out of the cells into the blood and is effectively locked in and converted into glycogen (glycogenesis). It is stored in that form in the liver. Glucose uptake and glycogenesis are controlled by insulin.

When glucose is needed again in the blood, adrenaline and glucagon stimulate the breakdown of glycogen (glycogenolysis) in the liver into glucose-6-phosphate. This is broken down further by phosphatase enzymes into free glucose, which is then released into the blood.

Muscle cells can take up circulating glucose where it is converted into glycogen by insulin. Glucose is also taken up by the adipose tissue where it is converted and stored as triglycerides. When energy reserves need to be released, these molecules are converted to glucose to be further broken down by cellular respiration.

Lipid metabolism

Monoglycerides and fatty acids are absorbed from the gut wall and reconverted to short chain fatty acids before being transported via the lymph to the blood stream.

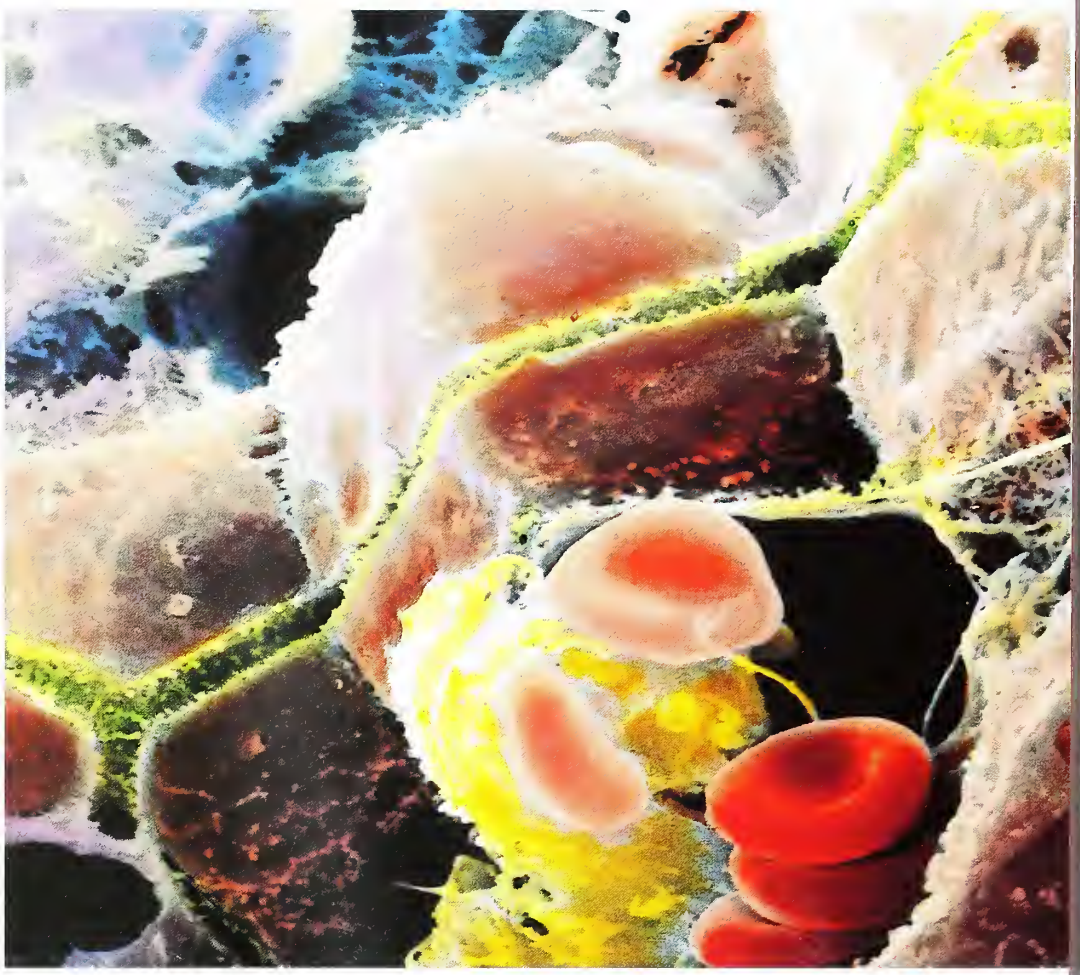
Most of the fat is removed from the blood when it reaches the adipose layers and the liver. Short chain fatty acids containing phospholipids and cholesterol, that are not taken up by the adipose tissue remain in the blood and combine with high density lipoproteins. High density lipoproteins are taken up by the liver where they are broken down into free fatty acids, glycerol, free cholesterol and amino acids.

In the adipose tissue, the triglycerides are first broken down into fatty acids by lipoprotein lipase so that they can pass though the cell walls. Once inside the cells, they join with the intracellular glycerol to form triglycerides.

This occurs through lipogenesis, which is the synthesis of fatty acids in the cells in enzyme-mediated steps. Palmitic acid (16-carbon chain) is formed and can then be converted to stearic and oleic acid molecules (18-carbon chains). These fatty acids then combine with glycerol to form triglycerides. Note that linoleic acid, from which arachidonic acid is derived, is an essential fatty acid and can be obtained only from the diet.

Fats are stored as triglycerides until they are needed. When they are, lipolysis occurs, which triggers the breakdown of stored triglycerides into fatty acids. These are then carried in the blood in combination with albumin and are referred to as free fatty acids.

Because lipids are insoluble in



Prof P Motta/Dept of Anatomy/University "La Sapienza", Rome/Science Photo Library

Liver cells, also known as hepatocytes, secrete bile which carries away waste products from the liver

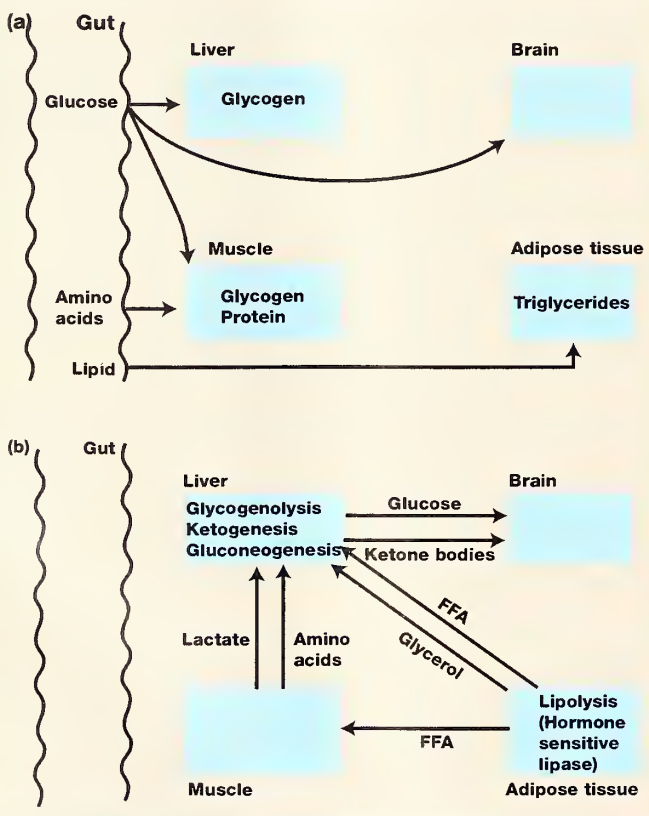


Fig. 3.2 Metabolism in the fed and the fasted state. (a) The fed state. (b) The fasted state. FFA = free fatty acids.

Energy

The main source of energy in the body is carbohydrate. It is taken in the diet and is broken down to glucose for absorption into the blood stream. Glucose is then transported to the cells and tissues where it is used for energy. Excess glucose can be stored as glycogen, which can in turn be converted back to glucose when needed.

Glycerol, fatty acids and amino acids taken in from the diet can also be used as a source of energy. Fat yields around 9 kcal of energy per gram compared to the 4 kcal yielded by proteins and carbohydrates.

Continued on page 28

This Christmas, AAH Pharmaceuticals will be making one *extra special* delivery...

Rather than sending all our customers a *Christmas card* this year, we thought it would be better to make a donation to the Coventry Myton Hospice Appeal. With the help from our donation, this new Hospice will increase the number of palliative care beds in the Coventry area, enabling patients to be closer to their homes, families and their friends.

AAH Pharmaceuticals Limited

Delivery schedule for the festive period:

Christmas Eve	Deliveries as normal
Christmas Day	No deliveries
Boxing Day	No deliveries
27 December	Deliveries as normal
28 December	Deliveries as normal
29 December	Deliveries as normal
New Years Eve	Deliveries as normal
New Years Day	No deliveries
2 January	Normal service resumes

In Scotland local restrictions apply. Customers should speak to their branch or BDM for specific schedules.

We'd also like to wish all our colleagues in Pharmacy a *very merry Christmas* and a *prosperous New Year*

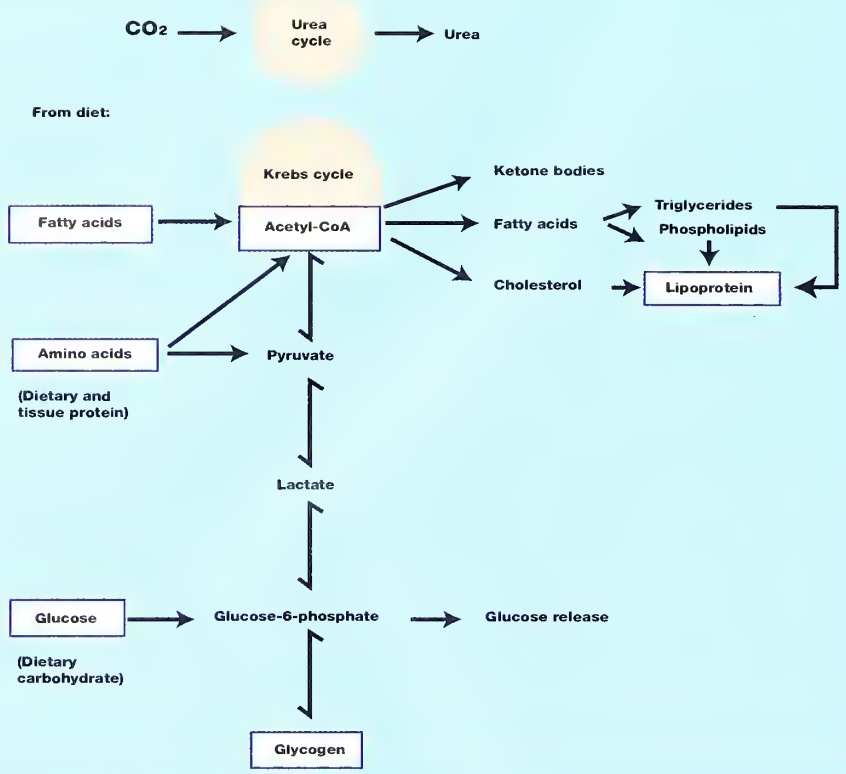


Fig. 5.2 Interelationships of protein, carbohydrate and lipid metabolism in the liver

◀ *Continued from page 26*

water, they are carried in the blood mainly as lipoproteins, which are synthesised by the liver. Lipoproteins come in different types depending on the ratio of triglyceride, cholesterol and phospholipid. For example, low density lipoproteins have a higher proportion of cholesterol compared with high density lipoproteins. A high HDL:LDL ratio reduces the risk of cardiovascular disease.

Energy in the form of ATP can be released from stored fat through fatty acid oxidation, which breaks down fatty acids and reduces fat stores. In reverse, excess carbohydrates and amino acids can be converted to fatty acids and stored in the adipose tissue.

Protein metabolism

Once absorbed from the gut into the blood stream, amino acids pass into the cells. However, the amount of circulating amino acids are maintained within narrow limits. If they fall below a certain threshold, it triggers the breakdown of cellular protein and release of amino acids into the blood.

Cortisol is responsible for the release of amino acids, while testosterone, insulin and growth hormone promote the uptake of amino acids from the blood into the cells.

In the cells, amino acids are used as building blocks for structural proteins or storage proteins or are oxidised to release energy. Synthesis occurs under the instructions of DNA and RNA.

Any excess amino acids not taken up by cells are broken down by the liver to keto acids and ammonia in a process called deamination (the removal of the amino-NH_2 group). Ammonia is converted to urea, which is eventually excreted in urine, while keto acids are oxidised through a number of steps to carbon dioxide and water.

Of the 20 amino acids, there are 11 non-essential amino acids which can be synthesised in the body by a process called transamination. Animal proteins can supply all essential amino acids but vegetable proteins may lack some of these amino acids. Vegans need to combine certain sources to ensure they get the full complement of essential nutrients.

Metabolic rates

The metabolic rate refers to the rate that energy is released from nutrients. It varies from person to person and depends on an individual's size, body fat, age, sex, activity and hormonal status. People with a slower metabolic rate tend to store nutrients rather than burn them up.

Children and teenagers have a higher metabolic rate than adults because their bodies are growing and changing. As they reach adulthood their metabolic rate slows down.

Basal metabolism

Basal metabolism refers to the amount of energy needed for the body to undertake basic activities and functions while at rest.

The daily basal energy requirement is calculated as:
Male: 1.0 kcal/kg/24 hours
Female: 0.9 kcal/kg/24 hours

For example, the daily basal energy requirements for a man who weighs 70kg will be 1,680 kcal. However, to calculate the total energy requirements this figure must be multiplied by a factor relating to the amount of activity the individual undertakes.

For a man with moderate activity levels, the daily basal energy requirement would be multiplied by 1.7 to give 2,856 kcal.

Actionplan

1. In your practice workbook, list nine common foods that are prime sources of proteins, carbohydrates and fats (three for each type). Record the main sites of their metabolism and the end products.
2. Using a suggested ideal one-day menu for an average working male (say, about 3,000 kcal), list how the three energy sources should contribute to the total.
3. Now calculate your own intake for yesterday. How close is your intake to the ideal? Think how you could modify your daily diet.
4. What are the effects of inappropriate diet? List them in your practice workbook.
5. Relate aerobic and anaerobic exercise to the metabolic pathways discussed in the article.
6. What diseases cause malnutrition? Do you have any patients suffering from such conditions? What is prescribed?

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the January 12 issue, which will cover this week's CPP-accredited modules, together with those in the December 1 and 15 issues.

The MCQ paper for the November modules is enclosed in this week's C&D covering:

- **Candida Part 1 (1217)**
- **Digestive system (1218)**
- **Ovarian cancer (1219).**

A faxback service for these modules and associated MCQs operates on 08705 441188 (premium rates apply).
A telephone marking service offers independent verification of results – details on the monthly MCQ papers.

in association with GENUS PHARMACEUTICALS

Weighty considerations

One more reason has been found why men should get rid of their beer paunch – adipose tissue produces oestrogen, which can mess up their sex life even if they are not short of testosterone, a conference heard last week.

Alcohol, too, can increase oestrogen levels in men for three to four hours after a drink.

Dr Eugene Shippen, author of the US best seller *The Testosterone Syndrome*, explained to an Andropause Society conference that both oestrogen and testosterone are important to both men and women. As the two sexes age, they become more alike in hormone balance, as women lose oestrogen and men lose testosterone.

Men produce about 15 per cent of oestrogen in the testes and the remainder from aromatase activity in peripheral tissues. The aromatase enzyme produces oestrogen from testosterone and its precursors and is particularly concentrated in central body fat, which increases with ageing. Too much oestrogen leads to decreased libido and erectile difficulty, even if testosterone levels are normal.

"Once men start to become obese, aromatase activity tends to increase," said Dr Shippen. "Losing weight improves the oestrogen to testosterone ratio."

Further advice is to avoid alcohol and to correct any zinc deficiency. Soy products seem to reduce free testosterone, so may help in preventing prostate cancer, but they may be bad for sexual function, he said. Low doses of aromatase inhibitors may also be useful in men whose erectile dysfunction is due to an oestrogen/testosterone imbalance.

Preventing prostate cancer

Another speaker advised men at risk of prostate cancer to take nutritional supplements. Professor Roger Kirby, who heads the department of urology, St George's Hospital, London, suggested that men with a family history of prostate cancer and a PSA above 2.5ng/ml should take vitamin E, lycopenes and selenium, particularly if they were considering testosterone replacement therapy.

Professor Kirby said the Government has decided to make PSA screening available on the NHS, as long as men are given leaflets explaining the pros and cons of the test, which is controversial. It produces a high number of false positives, subjecting men to the stress of expensive, uncomfortable and risky investigations, and its efficacy in saving lives is not proven. The explanatory leaflet has not yet gone to GP surgeries.

A more specific test is being used in some centres, which measures the ratio of free to total PSA. Free PSA tends to decrease in the presence of cancer.

"This test costs twice as much but we use it routinely in men with a PSA between 4-10ng/ml to reduce the need for biopsies," said Professor Kirby.

He recommended that men on testosterone replacement therapy, which can provoke prostate cancer, should have a PSA test before starting treatment and then annually thereafter.

He thought the Government was unlikely to introduce universal PSA screening. By the time trials looking at whether it reduced cancer deaths were completed in 2008, other tests would probably have become available using more specific markers. A better strategy still would be to develop treatments that cure prostate cancer, rather than screening populations to see who was most at risk.

Testosterone to prevent Alzheimer's

Professor Sam Gandy, professor of psychiatry and cell biology, New York University School of Medicine, told the conference that early research suggests testosterone replacement therapy might prevent Alzheimer's disease in men. Six men undergoing testosterone suppression therapy for prostate cancer were found to have raised plasma beta-amyloid levels. These levels rose to about double those seen before treatment started, and persisted for at least six months.

Professor Gandy said the link was unclear between raised plasma beta amyloid and the plaques of amyloid peptide seen in the brains of patients with Alzheimer's. But raised plasma levels might indicate a predisposition to the disease.

Studies in women have shown that if oestrogen levels go down, beta amyloid levels go up. Trials investigating whether hormone replacement therapy delays Alzheimer's disease in women will produce results in 2003, so there might then be a case for similar trials of testosterone replacement therapy in men. Another "exciting" possibility was the development of specific drugs that could regulate brain amyloids in men without producing feminising effects, the speaker said.

Scriptlines

Travatan treats glaucoma

Travatan (travoprost 40mcg per ml) eye drops solution has been launched by Alcon.

It is licensed for the decrease of intra-ocular pressure in patients with ocular hypertension or open-angle glaucoma, who are intolerant or insufficiently responsive to another intra-ocular pressure-lowering medication. It is suitable as monotherapy or as adjunctive therapy.

The dose is one drop in the affected eye once daily, preferably in the evening. Gentle closing of the eyelid is recommended after instillation as this may reduce the systemic absorption of the drug.

Ocular side-effects include hyperaemia, pruritus, iris discolouration and transient burning or stinging upon instillation. Headache is the only common systemic effect.

When substituting another antiglaucoma agent with Travatan, patients should discontinue the other agent and start using Travatan the following day.

For more information:

Price: £11.46
Pack size: 2.5ml
Pip code: 282-8846
Alcon Laboratories Ltd
Tel: 01442 341234.

Cough, cold & flu FORECAST

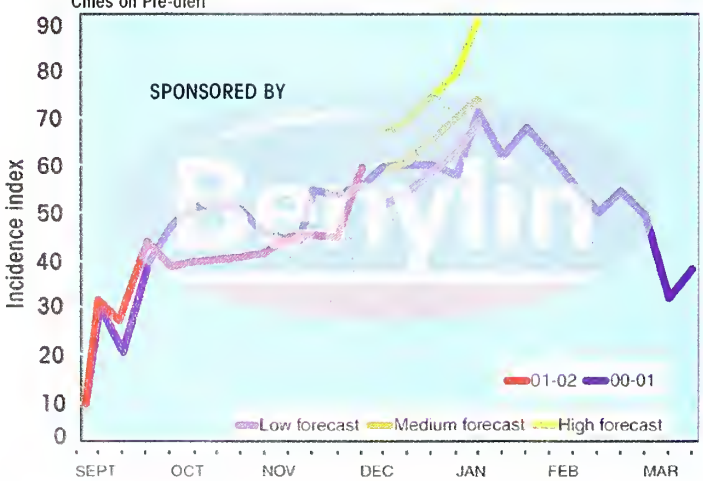
KEY FACTS

- The UK is now on Pre-alert status
- Bristol, Norwich, Manchester and Glasgow have reached Alert status
- *Coughing* incidence levels have reached 71 per cent

Benylin

Cities on Advisory Status
Cities on Pre-alert

Information updated weekly by SDI



Frontshop

Spray brings dual action to throats

Thornton & Ross is launching a pharmacy-only dual action throat spray in its Covonia range.

Covonia Throat Spray contains lidocaine, which acts as an anaesthetic to provide rapid relief and numb pain, and chlorhexidine – an antibacterial agent to fight infection and reinfection.

The product is sugar-free and therefore suitable for diabetics.

Covonia cough medicines will be supported by a £600,000 advertising campaign on TV from December 10 until the end of January.

Price: £4.19

Pack size: 30ml
Pip code: 281-2238
Thornton & Ross
Tel: 01484 842217.

Something to chew on

Remegel indigestion remedy will be appearing on TV screens nationally over Christmas and the New Year.

The brand will be supported by a £1 million advertising campaign on air from December 12 for four weeks.

The campaign is timed to meet consumer demand for a solution to over-indulgence during the festive season.

The new TV commercial highlights the brand as a "chewy not chalky" answer to painful indigestion, heartburn and trapped wind.

For more information:

SSL International plc
Tel: 0161 654 3000.

'Shut that cough up'

A new £1 million Meltus TV campaign will tell it straight on air nationally from December 17 until January 27.

A series of commercials for the cough brand feature short stories with a direct message.

The black and white animated sketches are targeted at the brand's main market – men and women aged 20-44.

The campaign supports the adult expectorant and night-time products in the Meltus range.

For more information:

SSL International plc
Tel: 0161 654 3000.

OTC brand changes

From January 1, Aventis Pharma's OTC brands will be sold and distributed via Chemist Brokers.

Pharmacists should place orders for Opticrom, Rynacrom, Brolene, Dioralyte, Anthisan, Oruvail and Phenergan with Chemist Brokers from January 2002.

For more information:

Chemist Brokers
Tel: 023 9222 2500.

GIVE YOUR CUSTOMERS SOMETHING TO SHOUT ABOUT

Now that your leading cough brand also has double action Sore Throat lozenges, you've got something to shout about.

Benylin

Presentation: Contains Hexylresorcinol 2.4mg per lozenge. **Uses:** Antiseptic, demulcent and local anaesthetic for relief of sore throat. **Dosage:** Adults and children over 6 years: Dissolve one lozenge slowly in mouth every 3 hours or as required. Max 12 in 24 hours. **Contra-indications:** Hypersensitivity. **Precautions:** Caution in fructose intolerance or related metabolic disorder. **RRP:** 24's £2.39 (ex VAT £2.03). **Legal category:** GSL. **PL Holder:** Ernest Jackson & Co Ltd., Crediton, EX17 3AP, UK. **Honey & Lemon PL No:** 00094/0036. **Redcurrant PL No:** 00094/0040. **Date of preparation:** July 2001.

Pfizer

Frontshop

Strepsils Extra uses state of the art 3D technology

Crookes Healthcare is supporting its Strepsils Extra throatcare brand with a £3 million TV campaign in the key cold and flu season.

A new computer-generated commercial uses state of the art 3D techniques to raise awareness for the brand.

The advertisement depicts a normal rural landscape that is not all that it seems. Blades of grass are literally "blades" and trees are constricted by barbed wire.

As the Strepsils Extra "sun" rises, the metal blades and barbed wire melt away to reveal a beautiful, lush landscape.

The commercial demonstrates what it feels like to have a sore throat and the relief that Strepsils Extra brings.

The eight-week campaign promotes the Black Cherry variant and will be on air from December 10.

For more information:
Crookes Healthcare Ltd
Tel: 0115 953 9922.

TV next week

Aquafresh Powerbrush: All areas *except* U, CTV
Aquafresh Toothpaste: All areas except U, CTV, TSW
Beechams: All areas except U
Benylin Active Response: GTV, STV, A, HTV, W, C4, Sat
Benylin cough range: All areas except U, CTV, TSW
Blistex: GMTV
Bodyform: STV, C, A, HTV, M, CAR, C4, C5, GMTV
Colpermin: C5
Day & Night Nurse: HTV
Gaviscon Tablets: All areas
Haliborange: GMTV
Macleans Ice Whitening: All areas except U, TSW
Meltus: All areas + Sat
Nytol: CAR, C4, Sat
Panadol: U
Remegel: All areas + Sat
Solpadeine: U
Sudafed: All areas except U, CTV, GMTV, TSW
Throaties Pastilles: GMTV
Venos: GMTV
Zantac 75: U
Zovirax: U

PharmaSite for next week: Day & Night Nurse – Window, **Day & Night Nurse** – In-store, **Midrid** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Benylin goes into action

Benylin Active Response and Benylin Children's Coughs are on TV this month as part of a £3 million investment in the brand.

The children's coughs commercial focuses on the importance of treating a child's cough to aid recovery and sleep.

The Benylin Active Response commercial depicts a man suffering from a cold being carried home from work on a stretcher by monk-like figures. He has resigned himself to a few days in bed... but his wife has other plans!

The TV campaign will run until late January, supported by national press advertising for Benylin Active Response.

For more information:
Pfizer Consumer Healthcare
Tel: 023 8064 1400.

Throats get Frank's help

Mike Reid (*Eastenders*' Frank Butcher) is starring in a £500,000 TV campaign for Throaties sore throat pastilles on GMTV until the end of February.

For more information:
Ernest Jackson
Tel: 01363 636100.

Scriptlines

Humalog colour change

Eli Lilly has developed a new colour scheme for the Humalog (insulin lispro) range in order to make the formulations more distinguishable.

- Humalog now has a vertical burgundy stripe
- Humalog Mix25 now has a vertical yellow stripe
- Humalog Mix50 now has a vertical red stripe

The new packs are being phased in during December.

For more information:
Eli Lilly & Co
Tel: 01256 315000.

SmPC update for Diovan

Following the removal of black triangle status from Diovan (valsartan) last month, Novartis has updated sections 4.4 and 4.8 in the SmPC.

Adverse effects now include cardiovascular syncope, diarrhoea, liver function abnormalities, arthralgia, dizziness, headache, cough and renal dysfunction and cases of renal impairment.

For more information:
Novartis Pharmaceuticals
Tel: 01276 692255.

Lanreotide in pre-filled syringe

Ipsen has launched Somatuline Autogel (lanreotide) injection in a pre-filled syringe in three strengths this week.

It is indicated for the treatment of acromegaly, when the levels of growth hormone and/or insulin-like growth factor-1 remain abnormal after surgery and/or radiotherapy. It is also indicated for the treatment of symptoms associated with neuroendocrine tumours.

The product, which must be stored between 2-8°C, is an addition to the existing LA preparation.

For more information:
Price: 60mg £542, 90mg £722, 120mg £932
Pack size: one syringe per pack
Pip code: 60mg 284-5865, 90mg 284-5873, 120mg 284-5881
Ipsen Ltd
Tel: 01753 627777.

CAN CUT THE LENGTH OF A COL...

Your typical Cold and Flu remedies provide short-term symptom relief but do nothing to shorten your customers' suffering. Now with new Benylin Active Response, you can recommend that your customers manage their colds in a completely different way. Whilst Benylin Active Response is not the first product to contain Echinacea, ours is most definitely not just "any Echinacea." Only Benylin Active Response features a specific part of the Echinacea purpurea plant and a particular process that results in a pressed juice that has been demonstrated in a double-blind, placebo-controlled clinical trial to reduce the average duration of colds from 8 to 4 days. Recommend new Benylin Active Response to get them back on their feet.

Benylin

Contains Echinacea Purpurea

Presentation: 100g oral solution contains 2.34g Dried pressed juice from fresh flowering Echinaceae purpureae herba. **Uses:** For the suppartive treatment of recurrent infections of the upper respiratary tract (e.g. caugh and cold). **Dosage:** Adults over 12 years 5ml three times daily; children 6-12 years: 5ml twice daily, children 2-5 years: 2.5ml three times daily. **Contra-indications:** Hypersensitivity to any of the ingredients or to plants of the Campositae family. Do not use in progressive systemic diseases such as tuberculosis, leukaemia, collagenosis, multiple sclerosis, other autoimmune diseases, or in AIDS or HIV infections. **Side and adverse effects:** Rarely, hypersensitivity. **RRP:** 75ml £4.29 (ex VAT: £3.65). **Legal category:** GSL. **PL holder:** Madaus AG, Ostmerheimer Str. 198, D-51109 Cologne. **Further infarmotion availoble from:** Warner-Lambert Consumer Healthcare, Eastleigh, SO53 3ZQ. **PL no:** 04638/0011. **Date of preparation:** July 2001.

Supplement your income with vitamins and minerals

As part of a series of product category reviews, Information Resources analyses the vitamins and minerals market in pharmacies. Each month a different pharmacy expert comments on how the product category is performing

The vitamins, minerals and supplements market is worth £354 million, and pharmacy sales (excluding Boots) account for £60m. The total market has remained fairly stable over the last year but with sales declining by 0.2 per cent. Sales through pharmacies (excluding Boots) have decreased by slightly more at 3 per cent.

The abolition of Resale Price Maintenance in May has had little effect on the category overall despite some price-cutting by supermarkets.

The market in pharmacies is dominated by Seven Seas, with value sales in the last year declining by only 1.2 per cent. Its most popular product is still cod liver oil, and it has recently launched the NeutraTaste range to appeal to a broader audience.

Roche is the second largest manufacturer with its core brands Sanatogen and Redoxon. Sales of Berocca vitamin B supplement, aimed at the 25-45 age group have continued to increase, up by just over 7.1 per cent.

As our lives become more hectic and stressful, the popularity of lifestyle products seems likely to continue. Sales of Seven Seas' Multibionta have increased by 47 per cent and have been extended into the over 50s sector with the launch of Multibionta 50+.

Boehringer Ingelheim's Pharmaton is another successful brand, with sales increasing by 23.1 per cent in the last year for Pharmaton and Pharmaton Vit-al Plus.

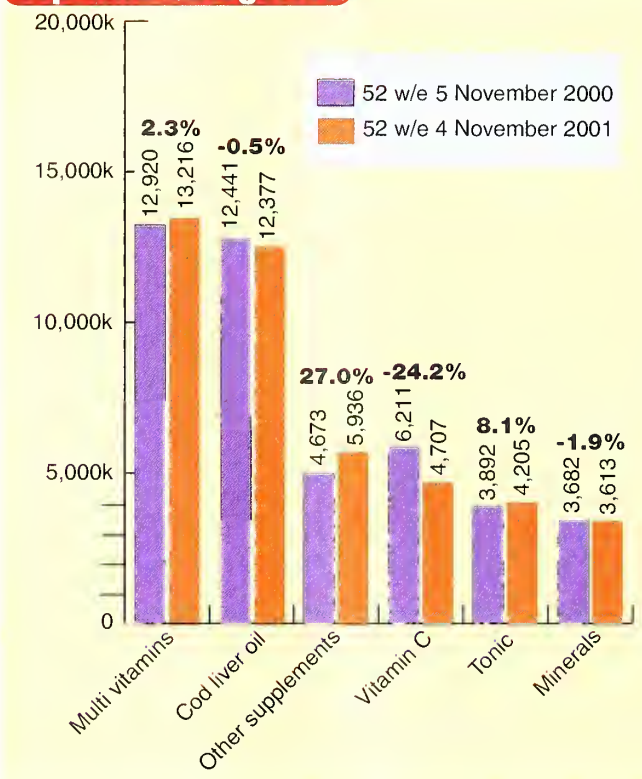
Meanwhile, the trend towards consumer-oriented products has helped Vitabiotics increase its sales by 22.3 per cent.

Sales of Minadex, a popular brand for children, have increased by over 17 per cent in the last year. Sales of Bassetts Jelly Babies vitamins, made under licence by Ernest Jackson, have also increased by over 29 per cent year-on-year.

Meanwhile, Centrum, from Whitehall Laboratories, is performing well in the multivitamins market. Promotions implemented since the abolition of RPM have helped it grow faster than any other "complete" multivitamin brand.

Consumers are generally more pro-active about their health, and the vitamins and minerals sector looks likely to stay buoyant.

Top VMS categories



Top pharmacy brands

1. Seven Seas Cod Liver Oil
2. Pharmaton
3. Metatone
4. Redoxon Vitamin C
5. Sanatogen Multi Vitamins
6. Health Aid Vitamins
7. Minadex Tonic
8. Sanatogen Gold
9. Seven Seas Multi Vitamins
10. Yeast Vite

Martyn Ward, sales and marketing director, Unichem

"Recent competition in the form of increased promotional activity from grocers has placed pharmacy sales of vitamins, minerals and supplements under pressure in pharmacy.

As the largest OTC category, with great profit potential for pharmacy, it is imperative that they fight back and do not allow further migration of market share.

Pharmacists should be concentrating on making sure that their product range is prominently displayed in a prime location and that the section includes strong, frequently-changed promotional activity to create interest and convey a value message.

There has been a tendency in the past for promotional prices to be passed on only partially (and in some cases not at all) to consumers.

This is a key issue, as other retailers are constantly promoting this category and we must ensure that pharmacy customers continue to regard their local pharmacy as the outlet of choice for VMS and related products, based upon a combination of range choice, advice and value.

The trend towards preventive healthcare has created a further opportunity for pharmacy in the form of herbal remedies, so staff training in product knowledge and the benefits of the VMS ranges and herbal remedies is extremely important. It is our main point of difference over supermarkets.

To maximise the opportunity for customer advice and link selling, the VMS fixture should be positioned close to the prescriptions counter.

To help those who would rather self-select, merchandising must be clear and concise. Due to the sheer number of products stocked by most pharmacies in this category, it is essential to make displays as logical as possible, with clear identification of each sub-section, for example "women's health", "children's supplements" or "energy" – one of the fastest-growing sub-categories at the moment.

Own-brand ranges play an important part in building profitable sales growth in both the VMS and herbals categories. In the last four years, own-brand labels have taken an increasing share of the market and now account for over half of all VMS sales.

Recognising this, we relaunched our own range of own-brand supplements in 1999 and added an extensive herbals range. These offer competitive prices to consumers and excellent cash margins for pharmacists.

Current estimates are that by 2005 the VMS market will be worth in excess of £400 million – pharmacists should act now to take advantage of this growth potential."

Martyn Ward: own-brand products are doing well


Pfizer
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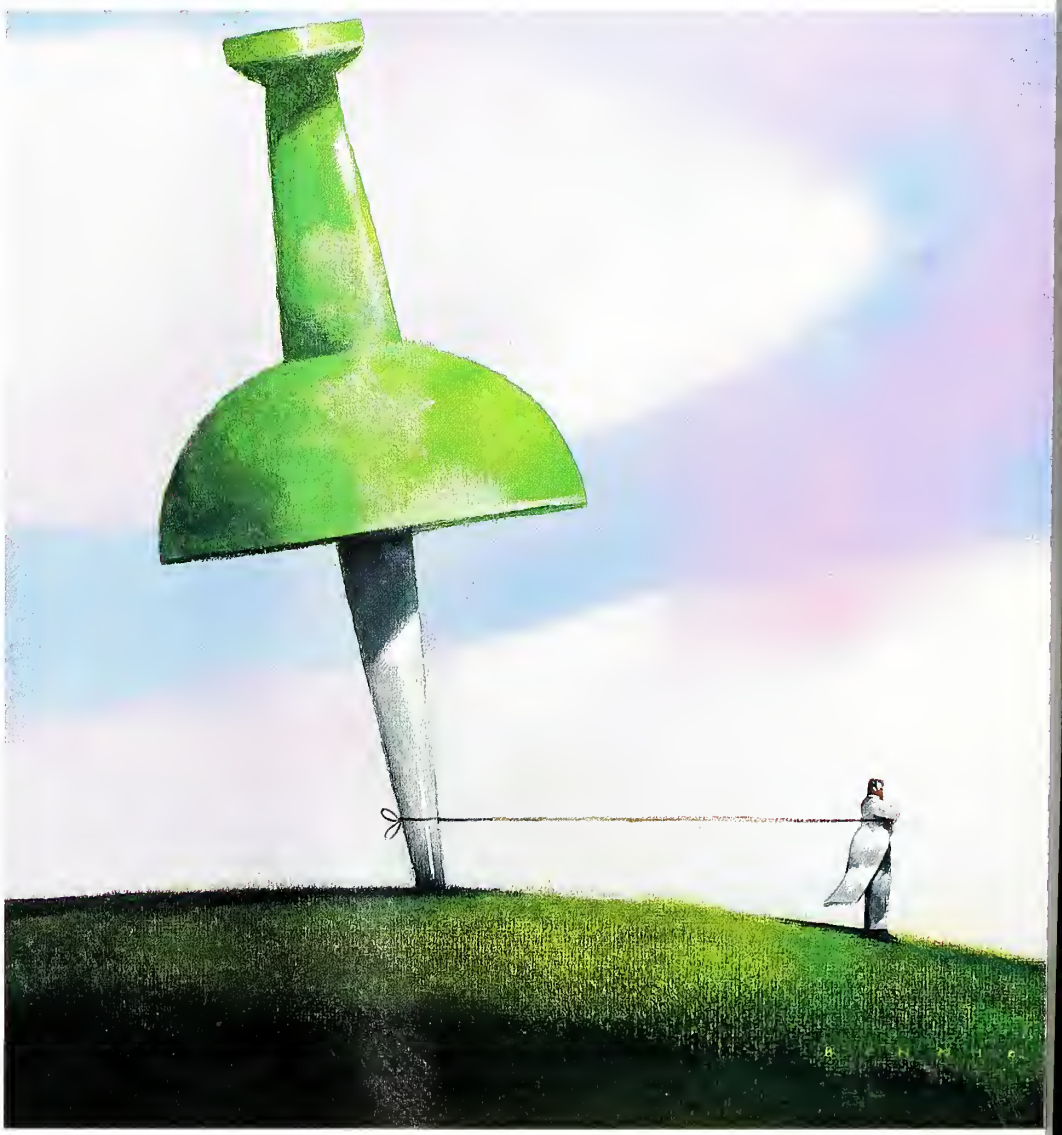
Take a dose for a healthy pharmacy this winter.
Winter is Pharmacy's key period. Benylin makes twice the contribution as the next winter brand through an established range featuring 11 out of 13 pharmacy-only variants. This makes Benylin the foundation of a successful season. So recommend Benylin for a healthy pharmacy.

A level play

Dr Darrin Baines argues that LPCs should avoid getting involved in redesigning local pharmaceutical services



Jason Bennion

Local pharmaceutical committees (LPCs) originally drew their authority from Section 44 of the 1977 NHS Act, which permits the Secretary of State to recognise committees that are representative of people providing pharmaceutical services in the locality of a health authority. With the publication of the NHS Reform & Health Care Bill, this is about to change.

Until now, LPCs have been based at health authority level within the NHS. If enacted, the Bill will change the level at which LPCs operate within the NHS in a way that reflects the abolition of health authorities in April 2002, and mirrors the growing trend of establishing primary care trusts (PCTs) to run the NHS locally.

Under Section 5(4) of the Bill, PCTs will be able to recognise an LPC formed for its area (or for the area of one or more other PCTs) if it is representative of people providing pharmaceutical services from premises in that area.

In other words, each PCT may agree to work with a particular LPC as long as it feels that the committee properly represents local pharmacy providers.

Under the Bill, PCTs will be mainly concerned with whether LPCs are representative, rather than with their size and structure. At one end of the spectrum, we could see large LPCs covering several PCTs but still able to represent all contractors in each area. At the other, we could see an LPC based on one PCT which refuses to recognise it because it considers it unrepresentative. In future, LPCs will need to focus on whether they are actually representing their local members rather than on the size and structure of their committees.

In this article I will:

- examine the purpose of LPCs and argue that, in a changing NHS, they need to reaffirm the principles upon which they are built
- argue that the procedures LPCs follow are more important than their structure when it comes to representing local contractors
- suggest that LPCs should concentrate on developing fair procedures for representing their members.

To an observer, it appears that

g field for all

LPCs are currently torn between evolving into mini-PCG/Ts, and retrenching their activities so that they are only concerned with professional disputes.

In the uncertain environment currently facing pharmacy, perhaps LPCs should avoid involvement in re-designing local pharmacy services and concentrate on making the local market for pharmacy services a fairer place.

Only by promoting a level playing field for local contractors can LPCs secure the type of representation I believe should be demanded by all PCTs.

Some contractors, of course, may feel this suggestion is "off beam" or far from their own vision of the future. I do not know what the final word should be on many of the issues raised here. I am simply trying to further the debate taking place locally on the future of LPCs within the NHS.

LPCs have been established to represent people providing pharmaceutical services in an area defined by a PCT boundary. This objective can be deconstructed into three main guiding principles:

- LPCs should be representative of all pharmacy contractors or "service providers" working in pharmacy (but not all providers of pharmaceutical services, such as dispensing doctors or nurses supplying drugs under patient group directions)
- LPCs owe an equal duty to all contractors they represent, regardless of their place of work, to support their interests as individuals and as a group
- LPCs should represent pharmacy contractors to the local PCT, and should be involved in building relationships with the local pharmaceutical advisers and PCT management.

With such guiding principles, LPCs must be impartial and fair. In an attempt to be representative, most LPCs have adopted a model constitution that dictates the number of pharmacy contractors, Company Chemist Association nominees, and employee representatives they can have on their committees.

Although it appears fair, it does not guarantee fair procedures are followed or equal outcomes are secured, as anyone with experience of committee work will know. With a bit of collusion, some loud voices and a detailed knowledge of the rules, a minority can easily manipulate a committee. Having rules governing the membership of LPCs only goes part of the way to promoting fairness for local contractors.

So far, LPCs have had a relatively easy time. The rules of engagement for pharmacy contractors are set nationally: all contractors are paid in the same way, the control of entry regulations have largely protected local businesses, and there is limited opportunity for doing real damage to existing outlets.

As a result, major conflicts tend to be short-lived, while friction between independents and national chains creates minor tensions just below the surface.

In the new NHS, all this may change. The Office of Fair Trading (OFT) is currently investigating the legitimacy of contract limitation, weighing public interest against competition law. A new remuneration system for contractors may be introduced, and local contracts for pharmacy services will soon be launched under the Local Pharmaceutical Services (LPS) scheme.

In this new environment, the tensions in existing structures will become more evident. Some contractors will struggle to adapt and two tiers may develop – those in the know and those struggling on the outside. To deal with the problem of uneven knowledge, power, resources and contacts between local providers, LPCs may need to re-consider what they mean by "fairness".

New policies for promoting a "level playing field" amongst local contractors should be considered. If a programme of training, resource allocation and network introductions is offered to each contractor, and LPCs are set targets for securing everybody's involvement, equality of opportunity could be secured.

Once each contractor is equally equipped, it is up to individuals to respond to the new opportunities open to them. By creating a level playing field, LPCs can still treat all contractors equally, but may be able to avoid the conflicts that will arise once local businesses pursue their own self-interest as NHS pharmacy suddenly changes.

In the coming months, LPCs will be stretched as new opportunities for pharmacists suggest that new procedures to ensure fairness should be put into place.

For instance, LPCs may have the opportunity to design local medicines management schemes, construct LPS pilots, decide local payment structures for work and influence the design of new incentive systems.

I would strongly suggest all LPCs should avoid any issues related to designing or running new pharmacy services for the following reasons:

- most new services will only involve a small proportion of local contractors, so LPCs risk their impartiality by promoting them
- health service issues – such as budget-setting or incentive design – involve specialist skills most LPCs may not have, even if their members are keen and want to be involved
- if LPCs are on the inside of the health service, they can't divorce themselves from the schemes they have championed if these fail. Involvement, therefore, automatically diminishes their ability to be truly representative.

In order to preserve their impartiality LPCs should re-trench and limit their involvement to issues solely related to proprietor representation. They should not try to re-design the system within which local pharmacies operate.

At present, national contracts, fixed dispensing fees and contact limitation mean that LPCs have relatively little to do compared to the tasks ahead. In the new environment facing pharmacists, the problems facing local contractors may grow as they try to adapt to unfamiliar working arrangements.

LPCs will need to re-examine their core activities and main purpose. They should acknowledge their limitations and strengths, and consult with all local proprietors before they embark on ventures such as designing LPS pilots.

If they consult with all interested parties, they may find some contractors object to the innovative ventures promoted by their local LPCs, as they will affect their commercial interests. By introducing a consultation process, LPCs can legitimise their activities and discover the boundaries of their roles.

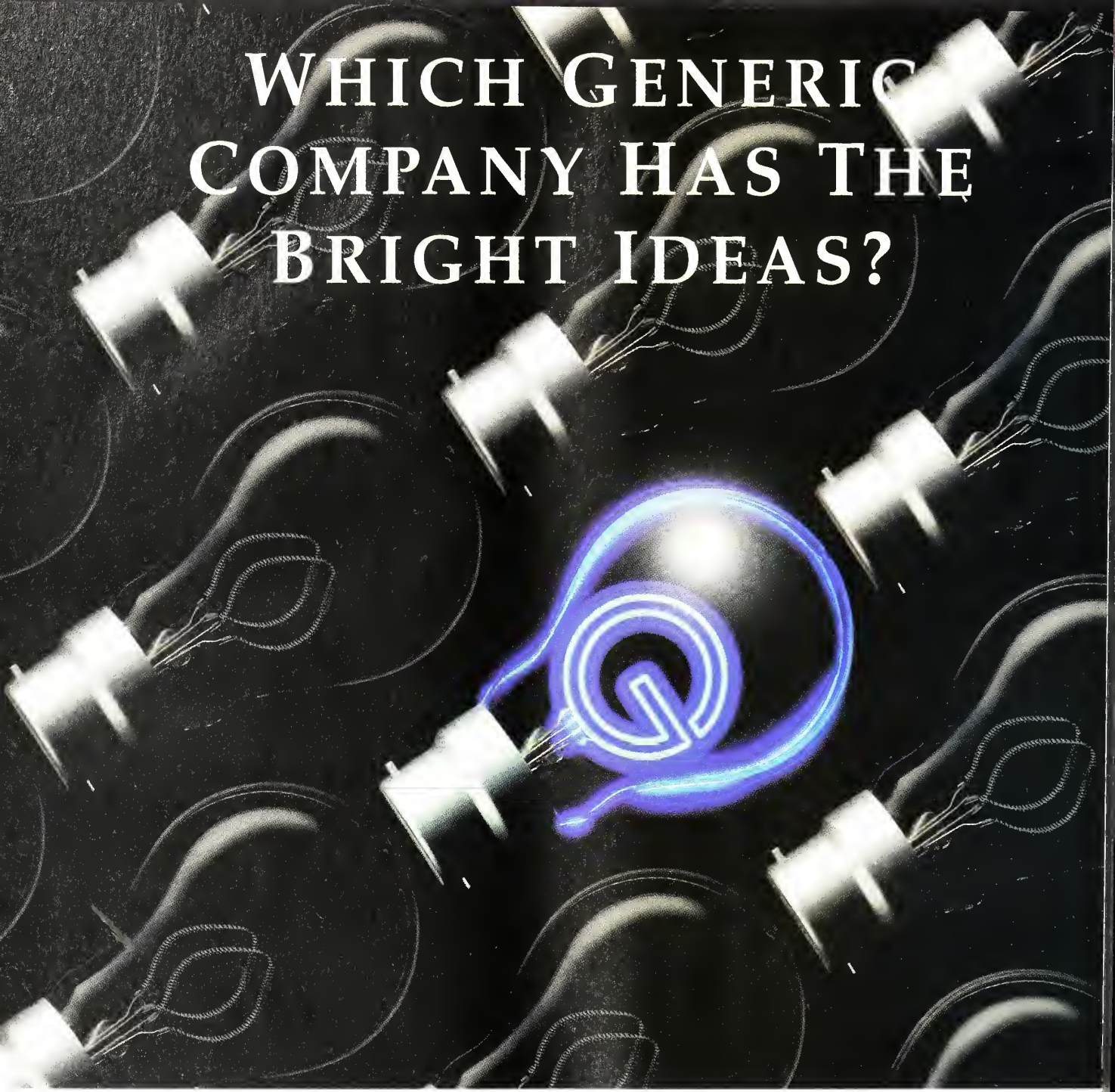
Indeed, consultation may indicate to some LPCs that they should focus on their traditional tasks, and should avoid evolving into specialist management bodies which lack the powers of their PCG/T counterparts.

LPCs may become more like local medical committees, which advise on many issues but let the important decisions be taken by their peers on the local PCG/Ts.

LPCs feel they should respond as the pharmacy and NHS environments evolve. However, sometimes the best way to respond to new challenges is to avoid them and stick to what you do best. If LPCs want to remain truly representative, their best strategy may be to remain locally based (Secretary of State permitting) and to pursue their core activity of resolving disputes rather than creating new opportunities for local pharmacies.

Although this message may not be welcomed in some quarters, I would suggest that LPCs should not decide their own futures but should outline different options and put their ideas out to consultation.

"LPCs owe an equal duty to all the contractors they represent, regardless of their place of work"



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No system is perfect

While the maximum price scheme for generic drugs has undoubtedly had some success, it is not a long-term solution, says Andrew McKeon, head of the DoH's medicines, pharmacy and industry division. Nina Keller-Henman reports

A new scheme for the supply and remuneration of generics could be in place well before the recently announced extension of the maximum price scheme expires.

"The next formal horizon is the 12 month review of the maximum price scheme, but I would hope that we'll have managed to find a way forward before then," says Andrew McKeon, head of the Department of Health's medicines, pharmacy and industry division.

Acknowledging the high level of uncertainty regarding the future of generics, Mr McKeon adds that "generics is a difficult and complicated issue and not one we want to rush at. But in some ways there could be a case for getting on with it and removing that uncertainty."

Retaining the status quo is definitely not an option as far as Mr McKeon is concerned. He is adamant that the maximum price scheme is not suitable as a long-term solution and that reform is therefore needed.

"One of the issues is how do you, over the long-term, actually fix the maximum prices?"

While the DoH has used prices from before the 1999 price-hikes as a benchmark to determine the maximum tariff for existing products, the question of what to do about newer products remains.

Neither does the maximum price scheme in itself ensure a consistency of supply, a key Government objective. There is also concern about the level of competition in the market.

OXERA's (Oxford Economic Research Associates) examination of the generics market also highlighted questions about value for money and vertical integration.

"The maximum price scheme does not really measure up against our objectives for a sustainable, long-term policy towards generics."

Mr McKeon still maintains that the Government does not see centralised purchasing as the preferred option.

"However, it is one of the easy options and has to be looked at."

Centralised purchasing has been dismissed as unworkable by just about everyone involved in the generics market, but Mr McKeon disagrees.

"Yes, it does remove incentives for competitive purchasing. But that is not something which makes it unworkable because the competitive element is introduced at a much earlier stage."

While accepting that the increase in bureaucracy associated with centralised purchasing is an issue, Mr McKeon believes that the cost implications do not necessarily render such a scheme unsustainable.

"We spend an extraordinarily little amount on running this system – in fact we could hardly spend less.

"Given the size of the market (around £700 million) and the potential value for money aspect it would be quite a long way until it became untenable to spend more and not make savings."

But what about the second option, a reference-based price scheme? "Not a scheme without its problems either - particularly as it is very much dependent on gathering good information at a particular level in the supply chain."

Mr McKeon certainly promises to explore the benefit-sharing scheme proposed by the various pharmacy bodies further *(see C&D October 27, p9)*.

"In essence that's what the current scheme is – if you can buy cheaper than the average you get the benefit," he adds.

Mr McKeon is more doubtful about the merits of a PPRS-like system for generics, as suggested by the British Association of Pharmaceutical Wholesalers.

"The whole point about PPRS (Pharmaceutical Price Regulation Scheme) is about monopolies and competition, which is the antithesis of the points stressed to us about the generics market."

He will, however, not rule out such a scheme at this stage.

Mr McKeon refuses to be drawn into a wider scale discussion about a comprehensive look at how pharmacists are being remunerated. However, he accepts that a lot of uncertainty has been created by the question mark hanging over generics and the Office of Fair Trading's inquiry into control of entry.

"The uncertainty does not help but actually the really important thing is the outcome."

He insists that pharmacy is still a viable business and points to positive developments which the Government has put into train recently - repeat dispensing, medicines management and pharmacy becoming the fourth disposition for NHS Direct.

"There is to be an absolute continuing need for pharmacies. It would be impossible to imagine life without community pharmacy."

His message to pharmacists is simple: stop worrying too much and focus on the opportunities outlined in the *Pharmacy In The Future* document.

"I can understand why people get concerned about what might happen but it is important not to forget the things that are actually happening."

"There is no perfect system, they all have their particular problems and issues associated with them"

Andrew McKeon: hoping to find a way forward from the maximum price scheme soon

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Product shortages are a real possibility

There is already a visible trend towards streamlined product portfolios, generics manufacturers tell Nina Keller-Henman. They also fear that the Government's proposals could make things a lot worse

Market consolidation and a reduction in product ranges appear not just a distant possibility but are reportedly already a feature of the generics market today.

Genus Pharmaceuticals, for instance, has reduced its tablet volume throughput by 60 per cent, which it says was due to market overcrowding for certain products.

Genus' sales and marketing director, Peter Ballard, says that by stopping production of some large volume but loss-making generics the company's bottom line has actually improved.

"It's only by making it a more attractive proposition that you can really stop the events of 1999 recurring"

At the same time he warns that, if too many licence holders follow suit, product shortages could occur once again.

"There has been some dumping in the market. Stock that was ordered in response to the shortages in 1999 is now coming to the end of its shelf life," Mr Ballard explains.

"If manufacturers don't re-supply there could be some shortages," he warns.

Generics UK's Richard Saynor (general manager, UK) adds that there is little incentive for generic manufactures to be innovative, as a lot of "run of the mill" products only carry a very small margin.

"Most companies will now examine their product portfolio. You've got to maximise the line that makes you money," Mr Saynor explains.

With most product licences now being pan-European, he adds that it is becoming particularly difficult for small, one-based companies, especially given the fact that four or five large companies produce 70 per cent of the volume.

As for his own company, he admits to pulling out of a small number of products, as has Alpharma.

Ivax (formerly Norton Healthcare) said it had so far not rationalised its product portfolio, but will conduct a review of product performances.

"It's a balancing act between reducing the portfolio to products on which you make a high margin and those that are in high demand but not necessarily profitable," says John Burden, Ivax's pharmacy marketing manager.

Mr Burden also acknowledges that the industry could do a lot to reduce costs to the NHS itself and drive down prices.

"I would be surprised if the industry was running at full efficiency. We need to make sure that our main manufacturing sites run at 100 per cent capacity."

Mr Ballard agrees that there is some over-capacity in the market but insists that the industry could only compensate for some of the reduction in product volumes.

He illustrates this point with an example: if five of the smaller players, with five per cent of the market each, pulled out of a particular generic, the volume produced would still fall to 75 per cent.

"The rest of the market could

Continued on page 44 ▶

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◀ Continued from page 42

only bring that up to 85 or 90 per cent," he insists, which would leave at least 10 per cent uncatered for.

The generics industry appears to be by and large united in the view that a tendering system would be unworkable and potentially increase the risk of shortages.

"The tendering option would be a Russian front, an unthinkable option that nobody wants to see," says Mr Ballard.

He believes, though, that the Government should take a more active approach in restricting the number of licenses it issues for a particular product.

"Ultimately, national tendering will become a reality, but it will evolve over time," he predicts.

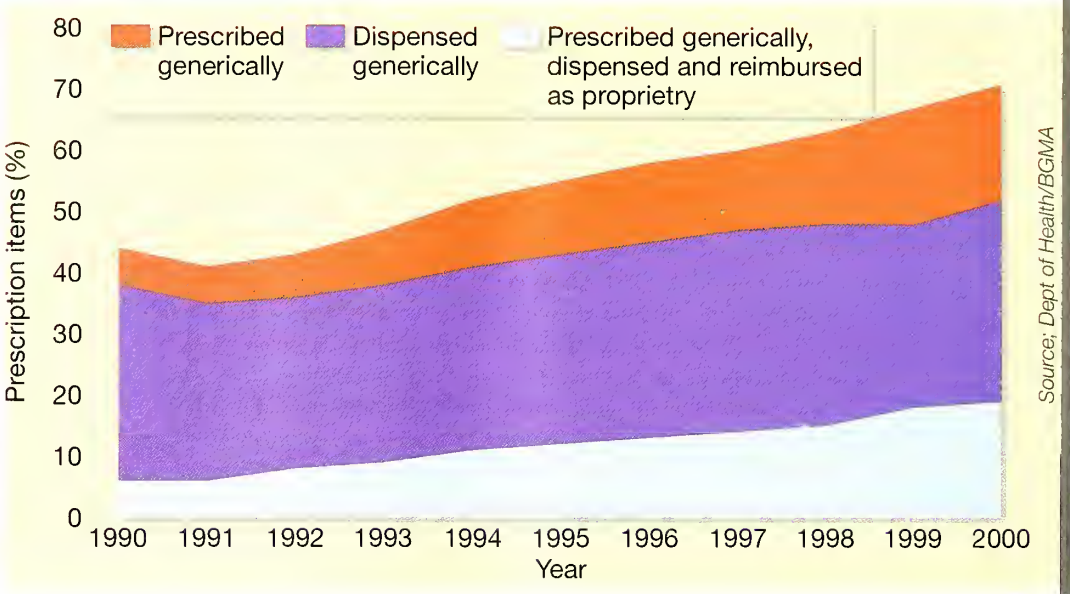
The tendering option also carries a strong risk of product shortages, explains APS Berk's deputy general manager, John Beighton.

"If we lost, for example, the atenolol tender and had ceased production, we could not just switch it back on if supply problems occurred."

He estimates that it would take a company between six and nine months to start production again, leaving the market short of stock in the meantime.

Meanwhile, the ambiguity that exists in relation to patient packs and bulks remains a much-discussed issue. There have been suggestions that manufacturers might be forced to return to selling bulk packs if the situation is not clarified soon.

"We are committed to patient packs and will keep our range in them. But if we find that through pure economics people are choosing to use bulk then it becomes a huge issue for us," says Mr Beighton.



Another issue highlighted by Mr Beighton, the incoming chairman of the British Generic Manufacturers' Association, is the recently adopted strategy of branded products being taken off the market ahead of patent expiry.

A prime example of this approach is the withdrawal of Clarityn (loratadine) and the launch of Neo-Clarityn- (desloratadine) by Schering-Plough.

"Doctors will be forced to prescribe desloratadine, and there will be no more prescriptions for the initial loratadine and therefore no market to launch into," Mr Beighton explains.

He adds that AstraZeneca had, unsuccessfully, tried to withdraw Losec (omeprazole) before launching Nexium (esomeprazole).

However, Mr Saynor believes that this approach is a rather dangerous one on the part of the innovative companies. He accepts that it may be effective in the short-term, but it also alienates the company from the prescribers and the purchasers.

"All it does is hand me a branded generic on a silver plate," Mr Saynor says.

Meanwhile Mr Ballard suggests that branded generics may be the way forward. Genus is developing a branded generic strategy and is in discussions with Discovery Pharmaceuticals. Discovery supplies a branded generic at a price somewhere between the generic price and the cost of the branded original.

Mr Ballard even suggests that the innovative companies should be encouraged to provide the generic themselves, but at the generic price.

Colin Darroch, managing director of Neolab Ltd, goes further.

"Why not say that once a product is off-patent the branded product would be reimbursed at the generic price?"

Both are aware that this could have a significant impact on the generics industry. For now however, the UK still appears to be a good market for generics companies to operate in.

"There are more products coming off patent in the next 18 months than in the 10 years before," says Mr Saynor.

But Mr Beighton warns that none of the proposals currently on the table would encourage companies to enter the UK market. "It's only by making it a more attractive proposition that you can really stop the events of 1999 recurring."

Mr Darroch thinks the UK would not be anybody's first choice in terms of entering a new market because of the number of competitors and the aggressive pricing.

But with the right product and a tight cost-effective operation, he says the UK can still be an attractive market.

Michael Barbour, of Thaxted Pharmacy, Thaxted, Essex, and winner of the UniChem Young Pharmacist Business Award 2001, looks ahead to 2020

Award winner Michael Barbour

Jason Bennion

In the year 2020...

The NHS Plan published last year threw down the gauntlet to pharmacists. How the current generation responds to this challenge will determine what the future holds. In the year 2020 I hope that I will be writing the following about community pharmacy...

All community pharmacy contracts are now negotiated at a national level with regard to dispensing services, and at local level with health board forums (formerly known as primary care trusts) for the added value services. The income of the average community pharmacy is split evenly between two sources.

At a national level:

All patients are registered with a specific pharmacy, from which all their repeat medication is issued and dispensed (a one-stop service). Acute medication, once prescribed, is available online.

Everybody carries an NHS smart card that enables community pharmacists to access prescription details and view the patient's medical information.

Some pharmacies still dispense prescriptions manually onsite. However, the majority either use automated dispensing machines or obtain the dispensed product direct from a wholesaler and act only as a point of distribution.

All prescribers must adhere to a strict formulary that is controlled by the National Institute of Clinical Excellence (NICE). Its introduction has led to the government purchasing all medications with a high volume of usage centrally under tenders, and then distributing them to pharmacies as required.

Drugs for acute prescriptions are bought locally and reimbursed by the government at agreed levels.

At a local level:

Within local areas, community pharmacies belong to commercially-active consortia. These are self-funding and run by a management board nominated by members.

Most groups employ a commercial manager with responsibility to negotiate service contracts with service purchasers – the health board forum (HBF). He or she also co-ordinates new pharmacy initiatives and oversees professional issues (eg clinical governance and evidence-based practice) within each member's pharmacy.

It is important to note that in some parts of the UK no action was taken at a local level as the NHS evolved through primary care trusts (PCTs) to HBFs. Pharmacies in these areas have now either perished (and been replaced by alternative prescription supply systems) or been seriously compromised with regard to their NHS income.

All community pharmacies are on the internet and provide services from prescription ordering to product purchases. Pharmacies can provide same-day delivery within their community.

All pharmacies meet strict levels of quality. They present a highly-professional image and concentrate on healthcare products in the retail areas. While some pharmacies provide a complete healthcare experience on the high street, smaller suburban premises have largely shifted into purpose-built health centres, within which one, two or three pharmacies have amalgamated.

The pharmacy remains the first port of call for minor ailments and offers a wide selection of medicines. Pharmacy products are allowed in any retail outlet with a qualified pharmacy technician, while Pharmacist Only medicines are only available from a pharmacist. Most pharmacies provide self-diagnostic machinery to test parameters such as cholesterol and blood pressure. Pharmacists and/or nurses with suitable training are available to provide advice and guidance on test results.

Information technology is a key element in community pharmacy practice. Protocols built into EposS systems prevent medicines being sold unless the correct protocols have been followed. Interactive screens in the retail area allow customers to browse databases and preview products not stocked on site.

Computer algorithms linked to NHS Direct allow patients to assess their risk of developing various diseases. Patients can also use these interactive screens to access their own medical records which can help them make better informed decisions about care.

Medicines management is facilitated with a patient medication screen positioned at the supply point in the pharmacy. Various programs enable the pharmacist and patient to discuss current drug therapy, address patient concerns and any compliance issues.

Patients unable to visit the pharmacy in person have the option of a pharmacy service in their own home using interactive portable computers, loaned out in a similar way to oxygen-giving sets. These counselling sessions have produced dramatic improvements in drug usage.

Community pharmacists have diversified their post-qualification skill mix. Continuing professional development is a cornerstone for a pharmacy career. All pharmacists, technicians and assistants must maintain professional reflective portfolios.

Suitably qualified pharmacists have become independent prescribers and have a limited formulary that they may prescribe on the NHS. Pharmacies stock, sell and dispense a wide range of alternative medicines. Herbal and homoeopathic medicine is extensively taught in all the schools of pharmacy.

Pharmacists are overseen by the Royal Pharmaceutical Society, but all regulatory issues are enforced by the NHS Lay Authority, an organisation set up to oversee and discipline all healthcare professions. Under the guidance of this new body, all pharmacists must now demonstrate their competence, attend regular study courses and undergo periodic assessment to maintain their registration.

The profession has come a long way from the uncertain days of the early part of the millennium.

Ple@se e-mail your views to chemdrug@cmpinformation.com

The relay race – is it going in the wrong direction?

I would like to pick up some points made by Hilary Baseley from Flexiscript (*C&D Letters November 10, p18*) in response to my article on ETP. Firstly there was no direct criticism of any of the consortia; the only concerns expressed were in relation to the relay system.

It was generally felt that the costs of rolling out the relay software compared to direct messaging (push method) would be more expensive, especially as such software tends to be in use already. Moreover, the current delivery of prescriptions to pharmacies and the Pricing Authority is free to the Government. There would be a cost disadvantage to go for a more expensive system (without added benefits) when we are hoping that it will pay for transmission fees and software.

One central server, no matter how well protected, is still one large target for opportunistic hackers and thus it is vulnerable – no system is hacker proof!

Moreover, the mirroring technique could also mirror errors and it is likely that if something went wrong it would be far more complicated to discover and rectify than if it were a direct "push" method.

My final concern, however, was how patients would directly benefit from the relay system when they might possibly have to wait longer for a prescription to be dispensed while the pharmacist had to find it and then dispense it. Stock might still need to be ordered and any queries would have to be dealt with "on the hoof".

I find it absurd that a patient has to call a pharmacy beforehand to speed up the dispensing procedure. Surely the system should fit around the patient, and not the other way around. How would pharmacists benefit from such a system, as well?

Mrs Baseley informs us that with relay prescriptions there will be a facility to add notes that could reduce phone calls with queries on the prescription. This presumes that any queries pharmacists might have would be known beforehand. Moreover, who would be legally responsible for these notes should something go wrong? Legal precedents suggest that liability would lie with the pharmacist.

My belief is that the push method will be a step closer to patient registration (bringing the same benefits that patients have from being registered with a doctor) and that there is little risk of GPs referring scripts (as proven by the repeat prescription collections from surgeries).

Finally, while it is true that the Scottish Executive has decided to go for the relay method, it must be remembered that the aims and objectives of the *NHS Plan* and *Pharmacy in the Future* will be different with the yet-to-be realised Scottish strategy.

Of course, quality patient welfare is the objective across the land but the priorities in achieving this will be different. In England, for example, two of the main criteria involve accessibility and patient convenience and I fail to see how the relay approach will beat the push method.

If the push method were to be chosen in England, Northern Ireland and Wales (after tendering) then it would be Scotland that was out of step.

Sultan Dajani
Council member, Royal Pharmaceutical Society

Selling the family silver could be a good move for the RPSGB...

As a non-pharmacist, I read with great interest the recent report of a proposed 31 per cent increase in fees levied on your profession.

As a professional economist, I would like to suggest that the Royal Pharmaceutical Society help its members pay their higher fees by selling-off its sizeable assets (perhaps through a share issue).

By turning its publications division, property portfolio and other substantial sources of revenue into income, the Society could simultaneously gain more rank-and-file support (which it seems short of) and make its members' lives easier (which would help compensate for the loss of RPM and the recent cut in the dispensing fee).

Like all good ideas, this may be ignored. Surely the extra monies coming from these non-fee sources would be welcomed by the RPSGB, whose critics are saying its attempts to promote a modernisation agenda seem to be back-firing and seriously affecting the profession's ability to survive.

Indeed, as I am sure many working pharmacists would agree, now is a good time to sell the profession's silver, as soon there may no longer be a safe home to house these assets in.

Dr Darrin Baines
MedM Ltd

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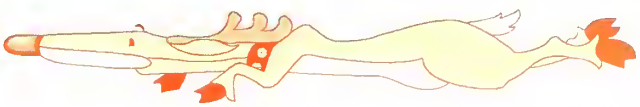

BOOKING DEADLINE for combined issue of 22/29 DECEMBER is 18 DECEMBER 12 noon


Ian Cooke

Ian Cooke has been appointed as depot manager for Phoenix Healthcare Distribution in York. Mr Cooke previously spent 20 years at the PHD depot in Burnley.

"This new job will certainly be a challenge," he acknowledged. "I'm a hands-on type of guy. I like to muck in and don't believe in asking someone to do something I can't do."

Generics UK Ltd has appointed **Richard Saynor,** formerly sales and marketing director, as general manager.

Adrian Sims is the new business development manager for Swains International, the photographic and telecoms distributor.

Spot the celebrity on daytime TV

Rumour has it that a certain member of Council, well known on these pages for his eccentric taste in shirts (*C&D, October 13, p46)*, has been seen on television.

Mr Dajani appeared on a show hosted by Robert Kilroy-Silk but was it:
a) Shafted – where contestants compete against each other to become the ultimate winner and go home with all the money
or
b) Kilroy – as a guest on the touchy-feely talk show promoting the role of pharmacists in domestic violence?

Those pharmacists with time to lounge about watching daytime TV will know the answer.

Check out the fidelity cheats

Pharmacists will be able to offer customers a new OTC infidelity test kit, just in time for the office party season.

Checkmate has been formulated to detect high levels of an enzyme produced by the prostate gland. The director of manufacturer Commercial and General recommends that undergarments are the best place to test.

"However, tests on the inside of shirts, blouses, bedding and car upholstery are also valuable."

The kit costs £59.99 and retailer discounts are available. Most pharmacists work in dispensaries, not offices, fortunately. Phew!

Anthea Smith, a pharmacy assistant at Munro Pharmacy in Chapelhall, South Lanarkshire, receives a bottle of champagne from Whitehall territory manager Elizabeth Lynch. Each month, counter assistants who have successfully completed C&D's Cambridge Counterpart training cours are entered into the prize draw to win a bottle of bubbly, so get studying!

Nine enthusiastic IVAX employees raised more than £3,000 for the National Asthma Campaign by taking part in the national Swim for Asthma event. The IVAX water babies swam more than 10 miles, at Newham Leisure Centre, to raise funds for vital research. Team leader Karen Howland said: "This is the third consecutive year we have taken part in the event and we have raised more money than ever"

Computer virus found in hospitals

Pharmacists should be aware of a report of a new computer virus acquired in hospitals. The report, in the *Archives of Disease in Childhood*, by Professor Isaacs from a children's hospital in New South Wales, Australia, suggests that the new viruses have evolved from a group of viruses by a process of "mutation, rotation, recombination, translocation, dislocation and extreme provocation".

Apparently, the viruses are common and worm their way into all aspects of hospital life. Examples include:

- the committee virus – typified by a blank screen with no message
- finance department virus – which flashes the message "Your department has spent money. Thi is an illegal operation"
- sexual health virus – "Hard dis too floppy. Take Viagra."

Symptoms take the form of a severe diskitis with diffuse widespread information.

Treatment is limited and the viruses are resistant. Unicyclovir may be effective but can be changed by the computer to recyclovir. A vaccine, containing a weak form of the virus which is barely alive, is otherwise known as a hospital administrator.

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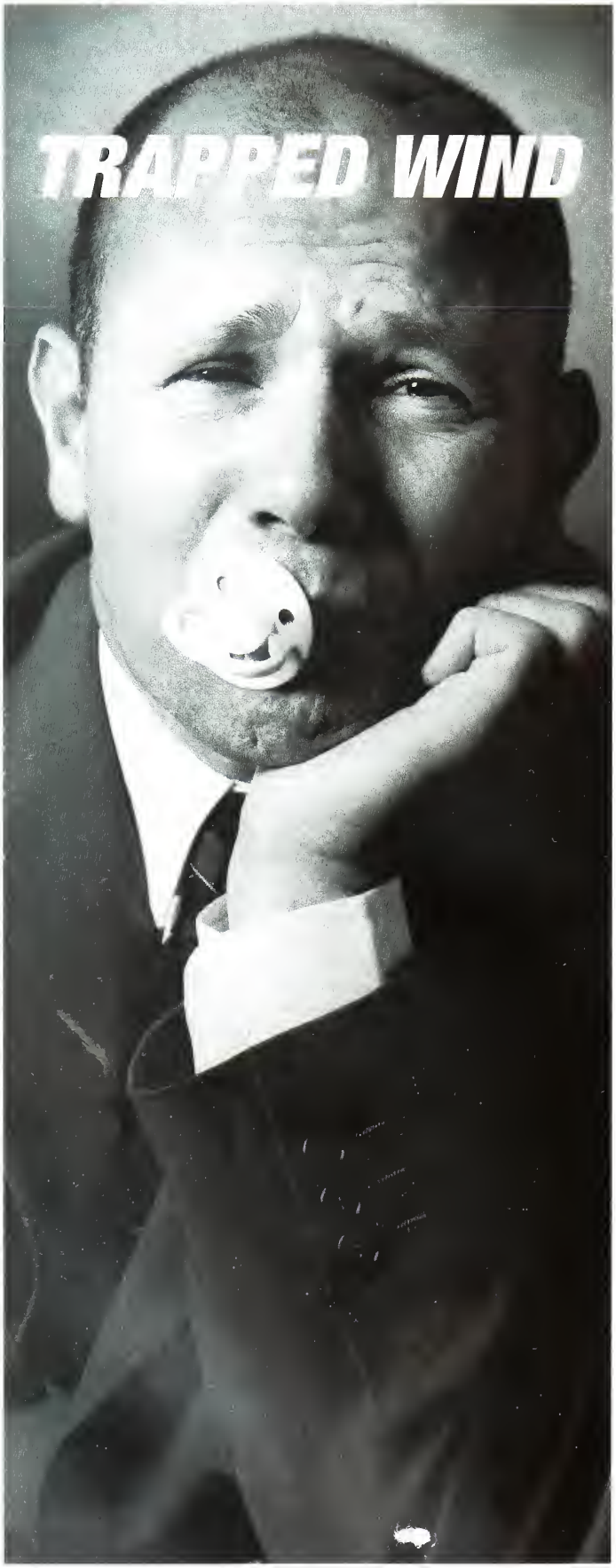
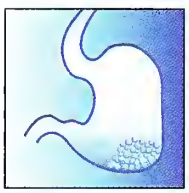


A PAIN FOR GROWN-UPS TOO

Everyone knows how painful and distressing wind in babies can be, but few people realise that trapped wind can be just as bad for adults. It's a common problem with almost 7 million people suffering from trapped wind; 17% of those on a daily basis. Remarkably, only 48% of sufferers request treatment and many mistake their problem for indigestion.[1]



WHAT IS TRAPPED WIND?

Our stressful, modern lifestyles mean more people are eating on the move or late at night and fast food is becoming increasingly popular. These factors all contribute to trapped wind. Trapped wind is when an excess of tiny air bubbles build up in the stomach and cannot be released.

This can be caused by:

- Eating food too quickly causing you to swallow too much air
- Specific types of food which increase the amount of gas produced (e.g. onions, beans, spicy foods)
- Sitting in the wrong position
- Eating on the move

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*(in *in-vitro* studies)

Product Information. Presentations: ***Setlers Wind-eze*** – Simeticone Ph. Eur. 125mg in a white tablet and ***Setlers Wind-eze Soft Gel Capsules*** – Simeticone Ph. Eur. 125mg in a white soft gel capsules. **Dosage & Administration** 1 tablet ***Setlers Wind-eze*** to be chewed before swallowing, or 1 ***Setlers Wind-eze Soft Gel Capsule,*** to be taken 3 or 4 times daily or as required after meals. Not recommended for children under 12 years. **Uses:** Antiflatulent defoaming agent for the symptomatic relief of flatulence, wind pains, bloating, abdominal distension and other symptoms associated with gastrointestinal gas. **Precautions:** Should not be used by patients with known hypersensitivity to any of the ingredients. Do not use for longer than 14 days. Seek medical advice if symptoms persist or worsen. May be used safely during pregnancy and whilst breast feeding. **Legal Category:** GSL. **Cost (inclusive of VAT):** ***Setlers Wind-eze*** – £1.95 (10's), £3.45 (30's). ***Setlers Wind-eze Soft Gel Capsules*** – £3.49 (20's). ***Product Licence Numbers: Setlers Wind-eze*** – PL0036/0084, ***Setlers Wind-eze Soft Gel Capsules*** – PL0036/0073. **Further Information**: GlaxoSmithKline Consumer Healthcare, Wallis House, Great West Road, Brentford, TW8 9BD. **Date of revision:** Sept 2001.

Reference:

1. Data on file, GlaxoSmithKline, 2000.

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